Regional Workshop on the Role of Parliaments in Combating HIV/AIDS

Windhoek, 21 - 23 February 2002

Acknowledgement

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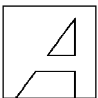

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COMMUNIQUE

Mr. T. Musavengana
Executive Assistant to the SADC Parliamentary Forum Secretary General

The SADC Parliamentary Forum organised a three-day workshop for Members of Parliament focusing on the **role of parliaments in combating HIV/AIDS.** The workshop was officially opened by Namibia's Minister of Health and Social Services, Hon. Dr. Libertine Amathila and was attended by twenty-one Members of Parliament from Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe.

Among other issues, the workshop was aimed at:

(i) Identifying and defining the role and capacity of the SADC Parliamentary Forum, its Standing Committee on HIV/AIDS, Committees of parliaments and parliamentarians and in addressing the HIV/AIDS pandemic in the SADC region;

(ii) Developing a SADC-wide Plan of Action on the role of parliaments in combating HIV/AIDS.

At the end of the three day workshop:

Noting the unprecedented impact of the HIV/AIDS pandemic in the SADC region;

Recognising and appreciating the sterling efforts of most governments, NGOs, the private sector and civil society in fighting the scourge of HIV/AIDS;

Conscious of the socio-economic and political challenges of HIV/AIDS to sustainable development, peace and political stability in the SADC region;

Aware of the millions of lives lost, millions orphaned and millions living with the condition;

Conscious of the leadership role that parliamentarians can play in seeking and finding a solution to this global crisis;

Committed to playing a leading role in promoting awareness and consensus on HIV/AIDS, as well as finding permanent, cost effective and sustainable solutions to the global crisis;

Participants resolved that:

- All member parliaments should establish Parliamentary Committees on HIV/AIDS;
- Parliamentarians should be availed with adequate resources, information and time to engage in HIV/AIDS related advocacy work in their constituencies. Such work should include workshops, seminars and visiting people affected and infected with HIV/AIDS. Parliaments should fund raise and support home-based care and other NGO, Community Based Organisations, civil society and faith-based initiatives;
- Members of Parliament are in a unique position to influence public opinion and confront the stigma attached to HIV/AIDS. They should use their position to be seen to support people living with HIV/AIDS and speak out against stigma and discrimination in communities, their constituencies and parliament;
- Parliamentarians should participate in the formulation of national budgets with the view to ensuring adequate budgetary allocations to the health sector, among other sectors;
- The subject of HIV/AIDS should be maintained on the agenda of all parliamentarians' meetings, parliamentary caucuses, political parties and in the business of all parliaments;
- All SADC Parliaments should review their respective legislation in line with International Guidelines on HIV/AIDS and Human Rights;
- All parliaments should facilitate, through legislation, the creation of HIV/AIDS funds to support people infected and affected by HIV/AIDS. Such funds should also be used for HIV/AIDS related local research;
- The SADC Parliamentary Forum should compile, analyse and disseminate information on HIV/AIDS related best practices in national parliaments as a way of harmonizing national and regional responses to the HIV/AIDS pandemic;
- The SADC Parliamentary Forum should compile accurate information on HIV/AIDS related research and intervention strategies with the view to building a valuable and easily accessible data bank on national, regional and international programmes on HIV/AIDS;

- The SADC Parliamentary Forum should formulate economic empowerment strategies aimed at harnessing resources and building the capacity of communities to respond to the socio-economic impact of HIV/AIDS;
- The SADC Parliamentary Forum should mobilize regional, inter-regional and international support for the fight against HIV/AIDS in addition to building on existing linkages with HIV/AIDS related networks;
- All SADC Governments should formulate National HIV/AIDS Strategic Plans and in so doing, parliaments should be actively involved in both the formulation and implementation of such plans;
- In addition to Parliamentary Committees, all SADC countries should establish National Multi-Sectoral HIV/AIDS Co-ordinating Committees/ Councils whose mandate will be to harmonise the efforts of the different sectors, including parliament;
- In line with the OAU Abuja declaration, parliamentarians should ensure that Governments set aside not less than 15% of national budgets to the health sector;
- Governments should allocate a specific percentage of the budget to HIV/AIDS initiatives;
- SADC Governments should create, support and strengthen support systems for orphans and people affected by the HIV/AIDS pandemic;
- The private sector should be involved in supporting research, HIV/AIDS fund raising, constituency based HIV/AIDS intervention activities, orphan care and support for people living with AIDS.

The resolutions made at the Workshop will be consolidated into a Plan of Action for adoption by the Plenary Assembly of the SADC Parliamentary Forum at its meeting in Luanda, Angola from 8 - 13 April 2002.

The Workshop was officially closed by the Speaker of the National Assembly of Lesotho, Hon. N. Motsamai, who called for closer co-operation and concerted multi-sectoral initiatives on HIV/AIDS.

Participants at the Regional Workshop on the Role of Parliaments in Combating HIV/AIDS, 21 - 23 February 2002

WELCOMING ADDRESS

Dr. Wolfgang Maier
Resident Representative of the Konrad-Adenauer-Stiftung in Namibia

Twenty years after the first clinical evidence of HIV/AIDS was reported, AIDS has become the most devastating disease mankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus worldwide.

HIV/AIDS is now the leading cause of death in Sub-Saharan Africa. Almost 30 million of the 40 million people worldwide living with HIV/AIDS at the moment live in Africa, most of them in Sub-Saharan Africa. In many countries of the region the new infections occurred in young adults, with young women especially vulnerable. About one-third of those currently living with HIV/AIDS are aged between 15 and 24.

This is the generation of our children. Many of them do not know they carry the virus. Many know nothing or too little about HIV to protect themselves and others against it.

But I am not a medical doctor, so do not expect me to talk about the medical or the pharmaceutical aspects of this disease.

HIV/AIDS, as tragic as it is to the individual and to the families, has a broader social, economic and political impact. Allow me to touch on some of these issues:

HIV/AIDS aggravates the changes of the **social structure** of societies, who are already affected by rural-urban migration, by changes of values, by the effects of globalization, by poverty and so on. AIDS is killing parents, leaving thousands of orphans behind.

AIDS destroys the social fabric of societies.

HIV/AIDS has a tremendous effect on the economies of our countries since HIV/AIDS is considerably reducing the qualified and trained workforce, it can negatively influence the potential investment in a country and it reduces the purchasing power in the economy and so on.

It makes poor people even poorer.

HIV/AIDS has become a political issue, since politicians have to take decisions concerning the allocation of public funds, they have to set completely new priorities. The enemy no longer comes from outside, the enemy is already in the country.

This enemy is killing millions of citizens, it is seriously hindering the future development of nations.

Please allow me to quote the former President of the Republic of South Africa, Nelson Mandela, from an interview he gave recently to the Sunday Times: “...This is a war. It has killed more people than has been the case in all previous wars and in natural disasters. We must not continue debating, to be arguing when people are dying...”.

In development policy we can no longer avoid this issue - even if we are not medical specialists - HIV/AIDS is no longer an issue of doctors, social workers, research fellows, the pharmaceutical industry and hospitals. HIV/AIDS has become a concern to all who are engaged in development and in politics.

These are the reasons why the Konrad-Adenauer-Foundation is supporting this workshop. We realised some time ago, that all our common efforts to support the development in the countries of the region are seriously impaired by the effects of HIV/AIDS.

It is my sincere hope that this workshop will provide information and will create awareness. It is my hope, that at the end of the day we are all aware of the problem, and we are also equipped with strategies to overcome this menace.

Members of Parliaments of all political parties - in a coalition - have the task to stand on the feet of their Governments to declare war on HIV/AIDS.

Please be lenient with me if I paint this bleak picture, certainly I would also prefer to talk about something nice. But in this case I think we do not have to lose any more time. We have to do something now, and we should not push away the reality. If we follow a realistic and co-ordinated approach, we are definitely not helpless!

I am particularly grateful to the SADC Parliamentary Forum, which has realised this and organised this workshop, and we are very grateful to the Namibian Authorities who have supported us. Finally, I would like to thank all the resource persons, who are providing us with first hand information and who share their experience with us.

Honourable Members of Parliament from various SADC countries: Welcome to this workshop!

You are playing an important role in the fight against HIV/AIDS!

INTRODUCTORY REMARKS

Dr. Khin-Sandi Lwin
UNICEF Representative

Thank you for giving me the honour of addressing this august gathering of parliamentarians from the SADC region.I am especially pleased to be a part of the process to bring MPs into the forefront - in leadership roles at the national and local levels - in the pan-ultimate struggle to reverse the tide of HIV/AIDS.

Looking at the objectives of the workshop and the topics it will cover, you will be getting a very comprehensive briefing. So, I will not go into all the different dimensions of the most devastating disease humankind has ever known. I am sure that you have heard ad nauseam about the impact of HIV/AIDS. Rather, let me address you as the politicians that you are. As politicians, your heart is with the people you represent.Without that close tie to and feelings for the human suffering your constituents are facing, you will not be very successful in your calling as leaders.

It is in that role as local leaders, closer to communities than the national leaders and the civil service, that Members of Parliament, Regional and Local Councillors, shoulder a particularly critical responsibility and role. There are some specific roles and tasks of Members of Parliament that already do part of the job in general but if done with intensity and single-minded purpose for HIV/AIDS, it will really make a difference.

From what we have learned from countries that have shown some success in stemming or reversing the tide of the disease, there are two most critical features: **leadership and community action**. Where leadership is unstintingly committed and fully engaged in the struggle, whole countries are mobilised across the sectors, government and private and at every level. Where communities open up their minds and hearts, confront the disease and take on the challenge to prevent further transmission and care for those already affected and infected, the disease is curtailed.

In your leadership role, some obvious and perhaps not so obvious roles and actions you can take are:

First, *questioning and challenging the civil service in terms of policies, programmes and budgets.* It is not just the obvious social development ministries such as Health, Social Services and Education that need

attention on the HIV/AIDS front, but each and every ministry. You are the people's check on the civil service and play a critical role in making sure that key investments in prevention, treatment and care are made and that plans and policies are carried through and actually reaching the people. The budget review sessions are an ideal opportunity to exercise that power bestowed on parliaments.

Second, and quite obvious, is *your role as legislators and policy makers.* Not all evils can be legislated against and having laws and policies does not mean that things will actually change. But by combining this with the first role, you hold in your hands very powerful instruments of governance and leadership. You hold in your power the determination of life and death issues such as access to treatment and care, the protection of property rights and inheritance for women and orphaned children and access to education for orphans.

Third, as leaders, *your capacity to mobilise action by others* is unmatched by any other group. Perhaps only the clergy might out-shine you on that score but you play a role in mobilising them as well. By informing, encouraging and supporting community-based and faith-based organisations or traditional leaders, you play that pivotal role in the kind of societal mobilisation that is needed.

Fourth, and perhaps not so obvious as the others, is that your leadership role means *you are a "model" that people look to emulate*. By taking a clear stand on erasing stigma and wiping out discrimination, each of you can make that special difference. For those of you who are HIV positive, taking that courageous step forward to declare your status would make such an impact on how society subsequently behaves and treats people living with HIV and AIDS. When well-known figures come forward, it becomes an accepted and "normal" disease. Perhaps there is a potential Magic Johnson among us. Only by giving voice and representation to people living with HIV and AIDS (PLWHA) can stigma and discrimination be undermined.

I am sure I do not need to say this, but it does not hurt to emphasise one of the most important characteristics of effective leadership, that is: keeping in touch with reality. How many of you have sought out and talked with PLWHA; dialogued with families with orphans; visited the paediatric and TB wards in hospitals? Only by seeing for yourself and understanding what people are facing, how people are suffering and how they are coping with

courage on a daily basis, will you be able to truly represent them and the interests of the nation.

Being in touch with reality also means that you need to understand the issues and characteristics - both humanistic and technical - of the disease that we are facing. It will require an extra effort to study with greater depth to be able to make informed decisions. This workshop provides that opportunity to learn. I hope you will be active listeners and learners. I am sure you will challenge the experts to give you their all.

It is when leadership loses touch with realities that the people have no hope. It is when leaders talk off the top of their heads and vote without real knowledge and understanding that the greatest damages are inflicted upon society. You are a powerful group of individuals and the futures of your countries are at stake. I wish you the courage and stamina to take on these challenges as individuals, as unified national assemblies with clear consensus on HIV/AIDS issues and lastly as a SADC network supporting each other across the borders.

The UN Theme Groups that consists of the co-sponsor agencies of UNAIDS (and other development partners in some cases) are there in every country of the SADC region. We are here to support you in your endeavours. We look forward to sustaining that partnership with you.

KEYNOTE ADDRESS

Dr. Khin-Sandi Lwin
Chairperson: UN Theme Group on HIV/AIDS

It is an honour and a pleasure for me, as the Chairperson of the United Nations Theme Group on HIV/AIDS in Namibia, to be here on behalf of the Joint United Nations Programme on HIV/AIDS to deliver a keynote address at this SADC Parliamentary Forum workshop on HIV/AIDS.

As most of you are aware, the figures relating to HIV/AIDS are shocking - with some 5.8 million new infections last year, the total number of people living with HIV/AIDS worldwide grew to more than 40 million by the end of 2001, an increase over the previous year.

Developing countries are particularly devastated by HIV/AIDS, with over 90% of cases occurring there and the majority of people living with HIV/AIDS not even being aware of their infection.In Sub-Saharan Africa, for example, AIDS is the leading cause of death. In 2001 there were approximately 3.4 million new infections. This brought the total number of people living with HIV/AIDS to 28.1 million in this region. At least 10% of those aged 15 to 49 are infected in several southern African countries.

What is the impact of these figures in reality? AIDS threatens the fabric of society. It challenges the future, as it disproportionately attacks young people, the leaders of tomorrow. Because the epidemic is concentrated in young people and adults at the peak of their economic and social productivity, AIDS threatens development.It is affecting global food security, decreasing the work force, decreasing life expectancy and increasing child mortality rate, increasing child death and increasing orphans/new dependants.

The challenge posed by the HIV/AIDS has led to a realisation that in order to be effective the *response needs to be expansive and inclusive.* This has two elements:

The first element is the involvement of all sectors (the international community, government, NGOs, private sector, local communities, people living with HIV/AIDS, the judiciary and parliament) in the continuing prevention, care, support and impact alleviation of individuals and populations.

The second element is the addressing of broader social, economic, political and cultural factors that make people vulnerable to HIV/AIDS. Addressing these inequalities means promoting and protecting human rights of people and promoting the fundamental principles of non-discrimination and equality: We now know that where human rights are protected, vulnerability is reduced, fewer people become infected; and those infected can cope better with the impact of HIV/AIDS.

In both of these elements you, as parliamentarians, are crucial. I wish to mention three specific ways:

i. *Advocacy of individual members of parliament is essential.* As political leaders you can influence public opinion and increase public awareness of HIV/AIDS issues and engagement of the private sector, trade unions, civil society and others members of parliament.

ii. As legislators you can *enact laws that promote human rights and that provide a supportive environment for HIV prevention and care*. Parliaments must adopt new laws and harmonise existing ones so that legislation protects human rights and advances effective prevention and care programs. Whether this be Constitutional amendments that prohibit discrimination based on HIV/AIDS or those most vulnerable to infection or sectoral legislation focusing on the education or employment sectors in the context of HIV/AIDS.

iii. As *resource mobilizers*, when examining the budget, members of parliament can seek to ensure that sufficient financial resources are mobilised and allocated for national HIV programs.

UNAIDS has long recognised the need for parliamentarians around the world to deepen their understanding of HIV/AIDS and the connection between HIV/AIDS, law and human rights. It is in this connection that in the last couple of years UNAIDS and the Inter Parliamentary Union (IPU) developed the "Handbook for Legislators on HIV/AIDS Law and Human Rights".This Handbook is a unique tool that provides parliamentarians with critical information on their role in responding to the HIV epidemic.

The handbook provides:

- Information on the critical role of human rights in the overall response to the epidemic;
- Processes adopted in various parts of the world in HIV-related law and policy reform;

- Practical examples of how various communities, parliaments and countries have dealt with the area of legislation in the context of HIV/AIDS.

Further, the Handbook:

i. Documents the principles in the International Guidelines on HIV/AIDS and Human Rights;

ii. Analyses these principles from the perspective of the legislator.

UNAIDS is very committed to addressing the role of parliamentarians as central to the HIV/AIDS response and is very pleased that the SADC Parliamentary Forum is taking a lead role in this. We are also particularly pleased that the framework that SADC is applying advances human rights norms, standards and principles as contained in some of the tools developed by UNAIDS, including the *Handbook*.

UNAIDS is particularly pleased to yet again collaborate with the SADC Parliamentary Forum. UNAIDS knows that it can count on the long-term commitment of the SADC Parliamentary Forum and its members to the fight against HIV/AIDS, and to the protection, promotion and the fulfilment of HIV/AIDS related human rights.

We hope that this workshop will assist in translating action at national level. Our aim is to make a far-reaching difference at national level.UNAIDS looks forward to supporting national parliaments in this regard.

AIDS IS REAL

Nicole Höpker
Pupil at St. Paul's Secondary School,Windhoek

AIDS is a reality that faces each and every one of us. Over 25% of Namibia, which is one in every four people, is infected with the HIV. And unfortunately it is we, the youth, who are the most vulnerable. When people are young they believe that nothing bad could ever possibly happen to them, they still have their whole lives to live. It is always someone else who is facing problems, it is always someone else who is facing the risk of contracting HIV.

But they are wrong.HIV is not a distant threat; it is a present danger. It does not matter whether you are black or white, male or female, gay or straight, young or old. HIV targets anybody. It only asks one question of those it attacks, “Are you human?”

If you believe that you are safe, you are in the greatest danger. Everybody needs to protect themselves. You may not be gay, haemophilic or inject yourself with drugs, but you are still at risk. Sexual intercourse is the most common way in which HIV is spread. Sex is something that is there. We need to accept this fact, we young people especially. Accept it rather than deny it and say, “I don't want to think about this.”

Young people should have positive values about life and sexuality. They should form their own beliefs and values on sexuality and stick to them. If they do not want to have sex they must know that it is their right to say, “No!”

The word must be spread that you do not have to have sex to show someone that you love them. And you do not have to be promiscuous to be cool. How much would it help anyway if you had sex to be cool and contracted HIV? You would not have very long to be cool and would have a death sentence placed upon your head.

Young people must learn to show that they love each other in different ways: write love poems, cuddle, smile and just spend time together. Adolescents do not give each other cancer or heart disease because they believe they are in love. They give each other HIV.

Billions of dollars are spent on scientific research into the HIV pandemic, but at the moment the pandemic is winning. And we have been the ones who have helped it along. We have killed each other with our ignorance, our prejudice, our silence. We have to get out there and educate the world. Talk

openly about HIV and AIDS and help each other. People have a right to the correct information and to learn how to protect themselves.

HIV asks the right question when it attacks, “Are you human?” We must remember that people infected with HIV have not entered some alien state of being.They are human.They have not earned cruelty and do not deserve meanness. They do not benefit from being isolated and treated as outcasts. They are exactly what God made them: people.

They are not evil, deserving of our judgement. They are not victims, longing for our pity.They are people, ready for support and worthy of our compassion.

We must work together in Namibia, the black and the white, the male and the female, the gay and the straight, the young and the old, not only to prevent the further spread of HIV, but also to show compassion and understanding for those already infected. It is also important to remember those people who have lost their loved ones to AIDS, and the poor AIDS orphans, of which there were 67,000 in Namibia at the last assessment.

AIDS is a reality, a reality which we must stand together and fight against. Namibia ranks third in Africa with the number of people infected in the country. This is our country, these are our fellow Namibians, so let’s fight against AIDS and win the war.

OFFICIAL OPENING ADDRESS

The Hon. Minister of Health and Social Services
Dr. Libertine Amathila MP

The HIV/AIDS epidemic is different from any other epidemic the world has faced, and as such, requires a response from the global community that is broader than has ever been mobilised against a disease before.

Twenty years since the first report of a rare form of pneumonia affecting five homosexual men in Los Angeles, three things have become clear:

- That humanity is facing the most devastating epidemic in human history, the impact of which threatens development and prosperity in major regions of the world;
- That for all the devastation it has already caused, the AIDS epidemic is still in its early stages;
- That we are in a position to bring the epidemic under control.

The first twenty years in the history of an epidemic is only the blink of an eye. The other communicable diseases that ravage many parts of the world have been known for many centuries. Their patterns of spread have become well established and predictable. We can claim with some authority, that we have controlled and even eradicated some of them e.g. small pox, and eliminated polio and leprosy.

AIDS is unlike any other epidemic that we have faced:

- It affects every strata of society and does not discriminate on the basis of wealth, colour of skin, gender, age and nationality. The chief route of infection is through an activity of human reproduction. Only personal protection will prevent the infection;
- Young adults are its biggest target. AIDS kills people just when they are in their most productive lives;
- It has far-reaching ripple effects, on the economy, on the family, communities and for the generation of children left without parents;
- It remains surrounded by taboo and stigma, which constitute a huge barrier to effective responses;
- It spreads silently, so millions can be infected with HIV in a population before the impact is felt.

This silent spread and slow impact of AIDS have meant that the threat it poses has been consistently underestimated.

It is estimated that more than 60 million people worldwide have been infected with the virus, and twenty million have died ever since. HIV/AIDS is now by a large margin the leading cause of death in Sub-Saharan Africa and the fourth biggest global killer. Deaths due to AIDS are associated with an upsurge in the number of orphans.

In 2001 alone, an estimated 5 million people became infected with HIV, and half of them were young people between the ages of 15 and 24.There were an estimated 800,000 children under 15 - mainly infants - infected with HIV in 2001, and 580,000 child deaths as a result of AIDS.

Sub-Saharan Africa is the region of the world where the epidemic has been worst and where its impact increasingly threatens the stability of whole societies. Average prevalence in Sub-Saharan Africa is 8.8 % in the adult population (15 to 49 years old). There are seven countries, all in Southern Africa, where more than 20% of adults are infected with HIV, and a further nine countries where infection rates exceed 10%.

SADC countries have been hardest hit by the HIV/AIDS epidemic. Current figures from UNAIDS show that out of a total SADC population of 193,476,000, there are 11,950,000 adults and children living with HIV/AIDS. The HIV prevalence rates in women attending antenatal clinics in urban areas range from 1.2% to 43%.

HIV/AIDS is currently one of the greatest threats to global development and stability. It is a long-term humanitarian crisis of unprecedented proportions. The death and misery it has caused in the past twenty years surpasses all of the natural disasters that have occurred in that time combined. The HIV epidemic has not only disrupted many millions of individuals and family lives, it has threatened the stability of entire societies.

A fundamental part of our response to the epidemic must address how families and communities can cope with the consequences of the epidemic; e.g. whether many orphaned children will not go to school, because there is no one to pay their school fees, or no one to buy clothes for them and get them out of the house in the morning, or because they have to help cultivate the land in order to produce food. Already we are faced with child-headed households.

There is manifestly *greater political momentum* in addressing HIV/AIDS. We have learned that political leadership is required at all levels to marshal the necessary response and resources for the social mobilisation. As parliamentarians we are called upon to vividly demonstrate the necessary commitment, not through words of mouth, but concrete actions. The level of political commitment to addressing AIDS has dramatically increased on every continent - and not least on this continent, and very importantly, right here in Windhoek, Namibia, at this SADC Parliamentary Forum Workshop on HIV/AIDS.

International law requires states to show due diligence in preventing and responding to human rights violations. With respect to violations of physical, psychological and social integrity in particular, governments have a duty to prevent, investigate, and prosecute those committing such abuse. We read daily in our own SADC Region about child rape to cure AIDS and violence against women.

As elected leaders we do have the primary responsibility to honour and ensure the effective implementation of all the:

i. International Treaties, Declarations and Conventions;
ii. Regional Treaties, Conventions and Declarations;
iii. National Constitutions, Laws, Policies and Declarations.

The role of elected leaders in the facilitation and engagement of communities in the operationalisation of the above-mentioned, is no different from their expert counterparts, but poses a special challenge to them.

Elected leaders in particular have to facilitate and promote a wide range of measures to end inequality between women and men. It is of cardinal importance that all appropriate measures, including legislation, policies and guidelines, are undertaken to ensure the full development and advancement of communities, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality for all.

Only then will communities be in a better position to enjoy their rights and take care of their own health and that of their children and families.

Elected Leaders should advocate for the:

1. Adoption of legislative measures to ensure the protection and removal of all forms of discrimination against, and empowerment of affected and infected people.

2. Review and reform the laws and procedures applicable to access to resources, care and services to eliminate gender bias and ensure justice and fairness to women and children and men.
3. Reviewing, amending or repealing laws adversely affecting the status of communities affected by and infected with HIV/AIDS.
4. Introducing, as a matter of priority, legal and administrative mechanisms for communities affected by and infected with HIV/AIDS, to enjoy effective access to counselling, restitution, reparation and other just forms of dispute resolution.
5. Promoting the eradication of elements in traditional norms and religious beliefs, practices and stereotypes, which legitimise discrimination of affected and infected people.
6. Introducing and supporting gender sensitisation and public awareness programmes aimed at eradicating discrimination against women and children.
7. Encouraging the media to play a constructive role in the eradication of discrimination against communities affected by and infected with HIV/AIDS. The media must not sensationalise issues concerning HIV/AIDS, but adopt guidelines which ensure sensitive coverage of the issue, and avoid the perpetuation of stereotypes.
8. Introducing programmes and strategies for the eradication of poverty and promote economic empowerment of women and children.
9. Adopting and promoting policies and positive measures which ensure the equal representation of women and men in positions of leadership and real power in all spheres of public and private life.

   As elected leaders it is our responsibility to continuously update our knowledge on factors affecting our health and the health of our loved ones.

   When it comes to improving care for people with HIV infection, world attention has recently focused mainly on *drug prices*, in particular the price of antiretroviral drugs. But access to drugs is just one of the many things that people with HIV infection need if they are to live healthy, productive lives for as long as possible.

   - Millions of HIV-positive people do not benefit from care and support because they are unaware of being infected. Many are hesitant to

find out if they have HIV because of the shame and blame that is associated with HIV/AIDS. In addition, facilities for voluntary counselling and HIV testing are inadequate in some SADC States. I would like to congratulate those governments and non-governmental organisations that are making these services available.

- HIV/AIDS-related care and support needs are extremely broad. Due to long incubation periods, HIV positive individuals will need counselling and positive living e.g. better nutrition, management of opportunistic diseases and follow-up. It is only in the advanced stages of the infection that antiviral treatment may be introduced based on the viral load assessment and CD4 count.
- People with HIV infection develop “opportunistic diseases” and distressing symptoms such as itching, pain, and difficulty in breathing or swallowing that require medicines and other forms of health care.
- They need support to cope with the psychological strain of repeated bouts of illness, and to counter discrimination and social isolation.
- They and their families need help to alleviate the economic consequences of sickness and death due to AIDS.

10. All over the world, communities affected by and infected with HIV/AIDS lack access to relevant information, and the resources and opportunities to develop skills needed to apply that information to avoid HIV infection. In our SADC Region it is safe to assume that information has reach the communities. However, knowledge about HIV/AIDS does not necessarily translate in behavioural change.
11. In many parts of our Region, communities affected by and infected with HIV/AIDS may also have difficulty accessing HIV/AIDS services, because these services are typically located in health facilities that primarily serve women, such as pre-natal and family planning clinics. In Namibia, the Ministry of Health and Social Services is implementing a programme, which entails the prevention of HIV transmission from infected mother to her unborn baby and the treatment of both parents in order to prolong their lives and prevent early orphanhood.

HIV/AIDS is a global problem, but it is a problem with a solution. The tools for effective responses exist. In the vast majority of countries around the

world, there are detailed plans for dealing with HIV/AIDS. Your Ministers of Health are doing just that. SADC countries have adopted a multi-sectorial approach that involves all sectors.

The SADC Heads of States have already taken a leadership role in addressing the problem of HIV/AIDS. We should not fail them. We should make it a point that we address the issue of HIV/AIDS at every occasion in order to sustain the required level of awareness.

PROGRAMME EXPLANATION AND WORKSHOP OBJECTIVES

Mr. T. Musavengana
Executive Assistant to the SADC Parliamentary Forum Secretary General

Programme Objective

To develop the capacity of the SADC Parliamentary Forum and through it that of the more than 1,800 MPs in the SADC region to develop regional anti-HIV/AIDS intervention strategies with the view to influencing regional and national policies on HIV/AIDS; through the exchange of information and experiences between and parliamentarians, policy makers, non-governmental organisations, the media, and HIV/AIDS experts among others.

Broad Workshop Objectives

To identify and define the role and capacity of the SADC Parliamentary Forum, its Standing Committee on HIV/AIDS; and that of relevant national parliamentary committees in addressing the HIV/AIDS pandemic in the SADC region.

To draw up a Plan of Action in pursuit of the above.

Specific Objectives of the Workshop

The Workshop is aimed at:

i. Developing the capacity of the SADC Parliamentary Forum Standing Committee on HIV/AIDS to influence regional policy on HIV/AIDS;

ii. Developing the capacity of chairpersons of national HIV/AIDS (Health) Committees to influence national policy on HIV/AIDS;

iii. Familiarising parliamentarians with the international guidelines on HIV/AIDS and human rights;

iv. Exploring the model of All-Party Parliamentary Groups on AIDS and Parliamentary Committees as mechanisms of backbench parliamentarians' influence on national HIV/AIDS policies;

v. Identifying the role of parliamentarians in influencing HIV/AIDS policies and in the promotion of cross-party co-operation in pursuit of the same;

vi. To set in motion the process leading to the formation of HIV/AIDS parliamentary committees in all member parliaments.

Workshop Participants

The Workshop brings together the SADC Parliamentary Forum Regional Standing Committees on HIV/AIDS, Chairpersons of SADC Parliamentary Forum Standing Committees and Chairpersons and members of HIV/AIDS Committees in national parliaments in the SADC region.

Resource Persons and Facilitators

The Workshop is facilitated by resource persons who are experts and practitioners in the implementation of HIV/AIDS intervention strategies at national, regional and international levels. These are the Konrad-Adenauer-Stiftung, AWEPA, UNDP, GTZ, Ministry of Health and Social Services (Namibia), the UK All-Party Parliamentary Group on HIV/AIDS and NGOs among others.

CASE STUDY:

HIV and AIDS Status in Botswana

Botswana is facing an HIV/AIDS epidemic of enormous proportions. HIV/ADS has become the main killer disease in the country and the country is reported to be one of the most hard-hit in the world. Based on the antenatal surveys that are conducted annually, there is no doubt that Botswana's epidemic is worse than in nearly all other Sub-Saharan African countries. Close to 60% of medical and paediatric wards of the hospital wards are currently occupied by AIDS patients.

In Botswana, data on HIV and AIDS are obtained from the testing of pregnant women who attend antenatal clinics and this has been conducted since 1990 in Gaborone and spread nationally in 1992. The major urban areas include Gaborone, Francistown and Selebi Phikwe. Median HIV prevalence among antenatal clinic attendees tested in the major urban areas increased from 6% in 1990 to 43% in 1998.The tested under 20 years of age increased from 18% in 1992 to 33% in 1998.Among women 20 to 29 years of age, 45 to 48% tested HIV positive.Though there were no statistical data on HIV prevalence for the years between 1985 and 1987 in the rural areas, it shows that it increased to 30% in 1995 and has remained at that level through to 1998. HIV prevalence ranged between 22 and 38% in 1998. HIV prevalence among tested antenatal clinic attendees under the age of 20 increased from 7% in 1992 to 36% in 1995. In the year 1998, 29% of antenatal clinic attendees under the age of 20 years were HIV positive.

HIV infections are monitored amongst men attending clinics for the treatment of sexually transmitted diseases (STDs) and this started in Gaborone in 1992. The testing spread to Francistown in 1993 and Selebi Phikwe in 1998. Some surveys on HIV prevalence among male and female tuberculosis (TB) patients have been conducted in Botswana. Based on these surveys, there are indications that HIV infections are on the increase in different parts of Botswana, except for Francistown. The hardest hit age group tends to be between 15 and 49 years.

By the end of 1999, it was estimated that there were 290,000 people in Botswana living with HIV/AIDS and of these, about 97% were adults (15 to 49 years of age). About 53% of this age group were women while the rest were men.This age group of both male and female gives a rate of infection of 35.8%.

Demographic Impact of HIV/AIDS

It was estimated that by the end of 1999, there would be 24,000 deaths in the country. Since the beginning of the epidemic until 1999, it is estimated that 66,000 children aged 14 years and below had lost either a mother or both parents.

Behavioural Indicators

A high proportion of Botswana (about 93%) aged between 10 to 64 years have heard about HIV/AIDS. There are, however, disparities regarding knowledge of HIV/AIDS between the rural and urban areas. The proportion is higher in urban areas (above 93%) than in rural areas (92%). Males recorded a significantly lower proportion than females. The proportions for females and males were 96.1% and 92.1% respectively. Another disparity was noted among age groups with the highest proportion of those expressing knowledge of HIV/AIDS being the 25 to 29 year olds while the lowest is the 10 to 14 age group. Despite knowledge, it is disturbing to realise that people still indulge in unsafe sexual acts. A survey conducted in 1996 revealed that about 15% of women sampled, aged between 18 and 25 years of age, had sex with a non-regular partner without the use of a condom.

Economic Impact of HIV/AIDS

There is evidence to show that HIV/AIDS is impacting negatively on the economy. At the household level for instance, there is a significant decline in income. Households affected by HIV/AIDS face two main additional types of expenditure, namely medical treatment and funerals. The number of destitute household will surely rise. Based on the 1993 household income and expenditure survey, households with a per-capita income of less than P10 per month increased by 2.1% and those with per-capita income of less than P25 per month increased by 2.5%.According to the Botswana Institute for Development Policy Analysis (BIDPA), this would amount to an increase of between 4,000 and 7,000 destitute households over the next ten years.

Government is already inundated with increased death benefits and pensions, increased spending on health and poverty alleviation, including allowances to the destitute and orphans. Government is, and will spend a lot of money on anti-AIDS drugs.

The private sector is weighed down by reduced productivity while workers are off due to illness or while caring for sick family members. There is also the problem of increased labour turnover, which adds to costs and increased spending on training to replace sick workers.

The Management and Implementation of the National Response to HIV/AIDS

1. High level Structure in Support of the National Response

As a response to the challenges posed by HIV and AIDS, the Government of Botswana and the people at large have committed themselves to vigorously fight the HIV/AIDS epidemic.

a) A National HIV/AIDS Policy

This was developed in 1993 to inform and guide a national response to the epidemic, and outlines the national response to the epidemic in Botswana.It spells out the role of national leaders, various government ministries, the private sector, non-governmental and community organisations, people living with HIV/AIDS, and individual community members in the national response.

In line with the national HIV/AIDS policy, some government sectors such as the Ministries of Education and Health and the Military, have also worked out their own HIV/AIDS policies that are specific to their own sections.

b) Legislation Against Discrimination

Though there is no specific legislation against discrimination on the grounds of HIV/AIDS, the existence of high-level structures in support of the national response to the pandemic is a clear sign of the seriousness government attaches to fighting the scourge.

c) National AIDS Council

A National AIDS Council has been established and is chaired by the President of Botswana. In this council, there are also representatives from government in the form of permanent secretaries, NGOs, religious organisations, the private sector, People Living with AIDS (PLWA) and traditional healers. A National AIDS Co-ordinating Agency (NACA) was established under the Ministry of Health and it serves as the secretariat to the National AIDS Council. Each Ministry has established a sectoral committee for HIV/AIDS.

d) District Multi-Sectoral AIDS Committees (DMSAC)

The DMSACs were established in order to facilitate the development and implementation of effective HIV and AIDS interventions at district and sub-district levels and work with Village AIDS Committees (VAC).

This came after a realisation that a national response to HIV and AIDS transcends the jurisdiction of the Ministry of Health and also that factors that facilitate the spread of HIV cut across sectors of society and economy. Each sector is to assess how it contributes to the spread of HIV and how the epidemic impacts on it. DMSACs have successfully acted as go between the service providers and recipients of such services through improved networking and collaborative arrangements at organisational level.

2. National Strategic Plan on HIV/AIDS

The National Strategic Plan that has been the basis for the national response to HIV/AIDS in Botswana over the last 5 years comes to an end this year (2002). The formulation of a new plan is already underway which will cover the period 2003 - 2008. This plan will be integrated into the Ninth National Development Plan (NDP 9) and the National Vision 2016 Plan to ensure that the activities are sustained beyond the plan period and that the different sectors will include regular budgets for activities that are based in evidence and within their competency. The National HIV/AIDS Strategy in Botswana has emphasised the participation of stakeholders other than government in response to the epidemic. These partnerships have proved crucial in helping the government to develop a comprehensive response to the epidemic. The following are some of what is in place as a result of the government partnership with the public and private sectors.

a) Voluntary Counselling and Testing Centres

The Tebelopele Voluntary and Testing Centres were established all over the country and provide HIV test results free of charge.

b) Total Community Mobilisation (TCM)

TCM Strategy has been implemented in Botswana for the past one year. The project is 80% funded by Government through the National AIDS Co-ordinating Agency (NAC) and 20% by Centres for Disease Control.

TCM programmes' point of entry is the communities themselves, so that community participation and ownership is enhanced. Districts provide co-ordination, guidance, collaboration and networking with health institutions, education, social welfare and other departments. There is evidence of high levels of awareness of HIV/AIDS issues in communities where TCM is being implemented.

c) Home-Based Care and Orphan Care

The programme started in 1995 and includes any form of assistance given to an ill person in need while at home. Family and community members provide care with the support of skilled health and social workers. The programme attempts to satisfy four basic needs of the clients, namely, psychosocial, physical, spiritual and material support.The number of people on home-based care has increased significantly with the advent of HIV/AIDS.

With orphans, every stakeholder identifies these and the Social and Community Development Division assesses and registers them. Government has established a food basket for orphans. Each orphan is entitled to the food basket worth P216.60 per month.

d) Coping Centres for People Living with HIV/AIDS (COCEPWA)

The concept of coping centres was introduced in the country by an NGO now known as COCEPWA, with the support of the government and partners such as the African Comprehensive HIV/AIDS Partnerships. The centres provide a co-ordinated community-based social support network for people living with HIV/AIDS, mobilising them in HIV prevention and care initiatives. Two centres are operational.

e) Antiretroviral Therapy (ART) Project

The programme of administering antiretroviral drugs has started and these drugs will be administered to patients of CD4 cell counts of less than 200 cubic millimetres. Since the number of eligible patients is unmanageable, pregnant women, their qualifying partners, patients with active tuberculosis, paediatric and adult in-patients are prioritised.

It should be noted that there is a budget for the implementation of the national strategic plan.

CASE STUDY:

The HIV/AIDS Situation in Malawi

The first AIDS case was confirmed in Malawi in 1985.Since then to 2000, a total of 55,00 cases have been reported. However, projections indicate that over 265,000 cases of AIDS have occurred so far.

The Virus

The causative agent for AIDS in Malawi is mostly HIV-1. There is no evidence that HIV-2 exists in Malawi.However, efforts are made to monitor for HIV-2 in blood donors, particularly because Malawi had an influx of refugees in the past few years from Mozambique, where HIV-2 is known to occur.

Mode of Transmission

The major mode of HIV transmission in Malawi is heterosexual. Data on AIDS cases collected so far indicates that approximately 90% of cases are due to heterosexual transmission. About 8% of cases are estimated to be due to mother-to-child transmission. The role of blood transfusions and unclean needles has been difficult to ascertain. It may contribute to the remaining 2% of the cases. Other modes of transmission, e.g. intravenous drug use, play a minimal role if at all in the transmission of HIV in Malawi.

HIV Seroprevalence

Even though the first case of AIDS was confirmed in 1985, it is believed that HIV infections may have started in the 1970s. Estimations of HIV prevalence were first made in 1985 at Queen Elizabeth Central Hospital (QECH) in Blantyre, here, the prevalence in pregnant women was estimated at 2%. By 1993 in Blantyre the HIV prevalence in women attending antenatal clinics had increased to 30%. Since then, however, the prevalence seems to have levelled off, and was 31.8% in 1994, 32.7% in 1995, 34.0% in 1996, 30.8% in 1997 and 28% in 2001.

Before 1992, estimates of HIV prevalence in women attending antenatal clinics was mostly restricted to urban health institutions; St. John’s Hospital in Mzuzu, Lilongwe Central Hospital in Lilongwe and Queen Elizabeth Central Hospital in Blantyre. From 1992 onwards, the health institutions where HIV prevalence was estimated were expanded to include urban, semi-urban and rural sites. In all the sites it appears that the HIV prevalence rate had levelled off by 1993. However, the prevalence levelled off at higher endemic levels in urban than in semi-urban and rural sites.

The reasons for the apparent levelling off of the prevalence are not clear. This could be due to increased AIDS-specific mortality rates as the epidemic matures and/or be related to reductions in new infections. However, stabilisation or even decreasing prevalence has been shown in Zaire to occur even in the face of very high incidences in some sub-groups of the populations, particularly the younger reproductive age groups. Thus, the stabilisation we are seeing here could merely reflect the dynamics of a maturing epidemic rather than a success of the interventions. This appears to be the situation here. We are seeing very high HIV levels in the younger age group despite the levelling off of the overall HIV infections.

The HIV prevalence from data from antenatal clinic attendees gives us an estimate of HIV prevalence in adults of the reproductive age group only (15 to 49). For 2001, this was estimated at 15%.

Using the HIV prevalence in the reproductive age group, the distribution of AIDS cases according to age group, and the population distribution in various parts of Malawi, we are able to estimate the national HIV prevalence. For 1999, this was estimated at 8%.

The majority of the population of Malawi is children aged 0 to 14 years. These account for about 47% of the total population. From our estimates, only 2.3% are HIV+ (mostly from mother-to-child transmission, antenatal and peer-natal). In absolute figures, about 5 million children are HIV negative. However, as they reach puberty and start engaging in sex, they become very vulnerable to HIV infection. This vulnerability is higher in younger women who tend to have sex with older male partners. The older male partners are at a higher risk of being HIV positive and therefore are likely to pass it on to the younger sex mates.

Information on HIV positivity rates in blood donors also indicates much higher HIV levels in young females (15 to 23) than in their male counterparts. The 1997 sentinel surveillance data indicated HIV prevalence of about 20.4% in antenatal women 15 to 24 years of age. We believe one possible explanation for this is that HIV is transmitted from older men to younger girls, who in turn as they grow and get married to their male age mates, pass it on to them. This is one very important pathway of HIV spread in Malawi. We need to devise ways of breaking this cycle. Great strides in the fight against AIDS in Malawi will be achieved by targeting effective interventions to the youth who are mostly HIV negative.

AIDS Cases

AIDS cases are reported from 60 health institutions distributed throughout the country. These are the sites where there is capacity, both equipment and manpower, to screen blood for the HIV. As stated earlier, the reported AIDS cases grossly underestimate the actual occurring. Many people die in homes without an HIV test.

Age / Sex Distribution of AIDS Cases

The age / sex distribution of AIDS cases from 1995 to 1998 was evaluated. The male and female cases are nearly the same from 0 to 14 years of age. From 15 to 29 years, female cases outnumber male cases, but the trend is reversed from 30 years onwards where there are more male than female cases.

There is a small peak in AIDS cases from 0 to 4 years, followed by a dip between 5 to 14 years. The highest peak of AIDS cases occurs in the age range 30 to 34 years. Overall however, the number of AIDS cases is the same in males and females. Over 85% of the cases are in people 15 to 49 years of age. Over 90% of the cases are in the age range 15 to 64, which represents the country's workforce. Similar trends are also observed when one looks at the AIDS cases data for 1992, 1993, 1994, 1995, 1996 and 2001.

Deaths due to AIDS

There is no reliable information on the number of people who are dying due to AIDS. This far into the epidemic, we believe that a lot of deaths due to AIDS have occurred. Conservative estimates put the cumulative figure of AIDS deaths close to 200,000. The high numbers of AIDS deaths may be contributing to the levelling off of the HIV prevalence. In 2001, it was estimated that up to 600,000 people had died of AIDS in Malawi since 1985.

Orphans due to AIDS

One sad by-product of the inevitable death from HIV infection in adults, are the orphans. The AIDS epidemic has contributed greatly to the orphan burden. Even though no accurate figures are available on the total number of orphans, projections using computer software have shown that we could have about 450,000 orphans as a result of AIDS. These numbers are more than the traditional coping mechanism of the extended family can deal with. This is another big societal impact of HIV/AIDS that must be addressed urgently within the context of the NACP. In 1998, it was estimated that up to 70,000 new orphans would be added to the pool annually.

Implication of the HIV/AIDS Epidemic

AIDS is mostly affecting Malawians aged 15 to 49 years, the age range of people who are economically productive. All aspects of the socio-economic structures are weakened by the epidemic. The most productive people in agriculture, secondary and tertiary industries, government and private organisations are being killed disproportionately by AIDS. It is projected that a minimum of 25% and as much as 50% of people currently employed in the urban-based sectors will have died of AIDS by the year 2005. The various sectors have to face increased costs due to lost working time as the employees start getting frequent illnesses on the way to developing full-blown AIDS and dying. They have to incur higher medical care costs and eventually funeral costs and terminal benefits. These effects of HIV/AIDS on the productive population call for careful and innovative ways of manpower planning and training.

The presently limited health care facilities cannot cope with the ever-increasing numbers of AIDS patients requiring us to pay more attention to alternatives such as home-based care. Over 70% of bed occupancy in medical wards of our hospitals is due to AIDS-related illnesses. In addition, TB cases have escalated with the HIV epidemic. It is projected that over 20,000 cases of TB will occur annually due to HIV. This figure is expected to increase in the coming years.

AIDS is a disease with a very long incubation period and thus the problem of AIDS patients, the requirements for counselling, hospital care, home-based care and support to orphans will continue to be with us from the back-load of HIV infections, even if new infections were to cease occurring. The challenges to the National AIDS Commission, and indeed to the entire Malawian nation, are huge. More so in the face of widespread poverty and illiteracy both of which are catalysts to the spread of HIV.

HIV/AIDS has affected all social aspects of Malawian life and requires a comprehensive multi-sectoral and well-targeted approach to dealing with it.

The National Response to the HIV/AIDS Epidemic

- The national response to the HIV/AIDS epidemic is co-ordinated through the National AIDS Commission. The national response to the epidemic has, in the last 10 years, been guided by a series of 5-year Medium Term Plans (MTPs).

- The first Medium Term Plan (MTPI) was implemented from 1989 to 1993. It emphasised issues of blood safety, IEC and management of Sexually Transmitted Infections (STIs).
- The second Medium Term Plan (MTPII) was implemented from 1994 to 1998.In addition to continuing issues identified in the MTPI, MTPII took into account the multisectoral issues of HIV/AIDS.
- A number of successes were achieved during the implementation of MTPI and II which include:
  - Almost universal awareness of HIV/AIDS in the general population;
  - HIV screening of all the blood donated for transfusion;
  - Adoption of the syndromic management of STIs;
  - Greater involvement of People Living with HIV/AIDS in the national response.
- However, despite the high awareness level, there are still quite high and unacceptable levels of new HIV infections.
- From 1998 to 2000, Government developed a Strategic Framework for HIV/AIDS for the years 2000 to 2004, to upscale and accelerate the national response. The Strategic Framework was developed in a participatory and consultative manner. The process aimed at breaking the silence on HIV/AIDS, mobilising the nation to action, and building capacity.
- The overall goal of the National AIDS Strategic Framework is to reduce the incidence of HIV and other sexually transmitted infections and improve the quality of life of those infected with and affected by HIV/AIDS. For ease of analysis, the National HIV/AIDS Strategic Framework is organised into nine inter-related thematic areas each of which has a specific goal, objectives and strategic actions to be taken. The nine thematic areas of the framework are as follows:
  - Prevention of HIV transmission;
  - Management of HIV/AIDS (care and support);
  - Information, education and communication;
  - Voluntary counselling and testing;
  - Orphans, widows and widowers;
  - Culture and HIV/AIDS;
  - Socio-economic status and HIV/AIDS;
  - Youth, social change and HIV/AIDS;
  - Despair and hopelessness in the face of AIDS.

- The major thrusts of the National HIV/AIDS Strategic Framework are:
  - Promoting and intensifying community-based responses, ensuring that gender concerns of the epidemic are taken on board all interventions;
  - Ensuring greater involvement of people living with HIV/AIDS;
  - Intensifying response for and with the youth;
  - Integrating care and prevention as the only meaningful way to effectively responding to HIV/AIDS.

Operationalising the Framework

The National HIV/AIDS Strategic Framework is a guiding document which is operationalised through a number of processes. These processes ensure the translation of the Framework into concrete interventions on the ground. The operationalisation of the Framework is through the following:

i. Developing a Behavioural Change Communication and Advocacy Strategy

Behaviour change remains the hallmark of the HIV/AIDS prevention, care and mitigation in Malawi. Only sustained positive behaviour and attitude change can ensure the success of any programme in addressing HIV/AIDS. In operationalising the Framework, a strategy that would move Malawians from general awareness to sustained behaviour and attitude change is being implemented. The Behaviour Change Advocacy Strategy not only looks at the adoption of low risk behaviours such as abstinence, mutual faithfulness and consistent condom use, it also addresses the reduction of stigma and promotion of a spirit of caring and support for People Living with HIV/AIDS (PLWAs). The behaviours and attitudes that are necessary for the successful implementation of interventions such as Voluntary Counselling and Testing (VCT), Prevention of Mother-to-Child Transmission (PMTCT), blood safety, care and support for PLWAs and orphan care, are advocated for through the Behaviour Communication and Advocacy Strategy.

ii. Mainstreaming HIV/AIDS in the Public and Private Sectors

The response to HIV/AIDS will be successful if it is comprehensive enough to involve the various sectors, both public and private. The National HIV/AIDS Strategic Framework therefore guides that all sectors must be part and parcel of the National HIV/AIDS response,

each one according to their capacity and comparative advantage. The operationalisation of the Framework has, therefore, included the implementation of HIV/AIDS mainstreaming programmes, including workplace programmes in the public and private sectors.

iii. Capacity Building for Implementation

Because the national response is broad and comprehensive, there is need for capacity building at all levels to implement the various interventions. There is need for capacity building at central level, at district level and at community level where activities are being intensified. Capacity building processes will be an integral part of implementation as the epidemic evolves and scaling up is done of lessons learnt from the various interventions on the ground.

iv. Development of Mechanisms for Co-ordination

The large number of actors in the national response to HIV/AIDS requires proper co-ordination systems that ensure use of the scarce human, material and financial resources and minimises duplication. The development of mechanisms for co-ordination has included the development of a national HIV/AIDS database for various actors and the development of co-ordination systems. The National AIDS Commission has been set up to act as a central co-ordination unit, which will work closely with other co-ordination units of various stakeholders. The Malawi Network of People Living with HIV/AIDS (MANET+) is being strengthened to provide co-ordination of support groups of People Living with HIV/AIDS. The co-ordination of HIV/AIDS support groups is being provided by the Malawi Network of AIDS Service Organisation (MANASO). To co-ordinate and strengthen working ties with the faith communities, a State-Faith Community Task Force has been put in place. The co-ordination with donor communities is being provided through the Expanded Theme Group on HIV/AIDS, the AIDS Co-ordination Goup and the Technical Working Group on HIV/AIDS. Consideration is being made for the formation of an Interministerial Committee and a Business Council to co-ordinate the public and private sectors respectively. Overall policy direction is provided by the Cabinet Committee on HIV/AIDS chaired by the Vice President and assisted by the Minister of Health and Population.

v. Strengthening Monitoring and Evaluation

A National Monitoring and Evaluation Plan is being developed.This will identify key programmatic indicators for monitoring and evaluation, including the implementation of second generation HIV/AIDS surveillance systems. More efficient management information systems will be developed to support planning and decision making. It is expected that a Strategy will be in place by August 2002.

vi. Developing and Implementing a Comprehensive Package of Care for PLWAs

The development and implementation of a comprehensive package for care that includes increasing access to antiretroviral drugs is an integral part of the operationalisation of the National HIV/AIDS Strategic Framework. This effort will complement prevention efforts in the behaviour and attitude change strategy, the sector specific plans and in the District Implementation Plans. This aspect of operationalisation of the Framework is detailed in a proposal for a Comprehensive HIV/AIDS Management Programme. The proposal was prepared by a multi sector team and was broadly consultative. The Proposal will be submitted to the Global Fund.

vii. Resource Mobilisation

To operationalise the National HIV/AIDS Strategic Framework, there is need for continuous resource mobilisation and monitoring resource inflows from both the international donor community and in-country. The in-country resource mobilisation includes increasing public budgetary allocation to health in general, and HIV/AIDS in particular and raising resources from the private sector. To ensure that the resources for responding to HIV/AIDS are made available to community groups, a grant management facility for community-based organisations and NGOs is being finalised. This will form one of the main channels for moving resources to communities to initiate or scale up HIV/AIDS interventions.

viii. Formulating a National HIV/AIDS Policy

A process has been initiated to prepare a broad Policy Framework within which the strategy will be implemented and monitored. Consultations have been completed and reports prepared, highlighting critical areas of policy. It is envisaged that a Policy will be ready by the end of 2002. This should give much needed impetus to programmes that have lagged behind for lack of policy guidance, and will form the basis for formulation of laws in the appropriate areas of HIV/AIDS.

CASE STUDY:

The National HIV/AIDS Strategic Plan in Mauritius

A. SITUATION ANALYSIS

1. General Background

1.1. *Demography*

The estimated mid-year (1998) population was 1,124,508 for Mauritius and 35,220 for Rodrigues. The adult (15 to 49 years old) population of the same time for Mauritius was 649,047.The sex ratio at all ages in 1998 was 999.7 male to 1,000 female. The Total Fertility Rate in 1998 was 1.96 for Mauritius and 2.26 for Rodrigues. The mean age of childbearing for Mauritius was 26.9 years. In 1998, the mean age at first marriage was 29.6 years for male and 24.8 years for female for Mauritius.

1.2. *Migration, Mobility and Displacement*

There are two types of population coming into Mauritius; tourists and migrant workers. The former stays in Mauritius for a short period of a few days or weeks and the latter stays in Mauritius a long period of a few years. During the year 1999, 538,085 tourist arrivals were recorded. On the other hand, an average of 13,000 people arrive in Mauritius every year to work in various industries. There are also many Mauritians who go out of the country for study, business and as tourists.

1.3. *Ethnic and Cultural Differences and Religion*

Mauritius is a multi-ethnic society. The population of 1.2 million has their origin on the three continents: Asia, Africa and Europe. There are also various religions in the country namely Hinduism, Christianity, Islam and Buddhism. Each religious belief is respected and seems to have strong influence on the peoples' values and daily practices. The associations related to religious groups are many and active in social and educational activities.

1.4. *Education*

Education is free from pre-primary to tertiary school. In general, Mauritius enjoys an adult literacy rate of more than 90%. In 1998, there were 285 primary schools; 272 in Mauritius and 13 in Rodrigues. The majority of schools (222) were run by government. In 1998, secondary education was dispensed in 133 schools, 130 in Mauritius and 3 in Rodrigues. In 1998,

34 schools offered technical and vocational education to pupils not attending the general secondary schools.

1.5. *Economic Situation*

The per capita GNP at market prices went up to MR 83,027 (USD 3,585) in 1998. In 1999, Mauritius was ranked 59th in the Human Development Index (HDI), among the countries with high human development achievement.

1.6. *General Health Indicators*

The crude death rate (per thousand) in 1998 was 6.8 for Mauritius and 5.3 for Rodrigues. The infant mortality rate (per 1,000 live births) in 1998 was 19.4 for Mauritius and 17.4 for Rodrigues. It was 57.0 in 1970 for Mauritius but has achieved dramatic reduction in these 30 years. The maternal mortality rate (per thousand live births) also declined from 1.71 in 1970 to 0.2 in 1998 for Mauritius. Improvements in the health status of the general population are also apparent in gains of the life expectancy at birth. From 1951 to 1953, it was estimated to be 49.8 years for male and 52.3 for female, compared to 66.6 for male and 74.4 for female in the period from 1996 to 1998.

1.7. *Health Services*

All health services in public hospitals and health centres are free of charge. There are 5 regional hospitals and 3 district hospitals on the island of Mauritius. There are also psychiatric hospitals and other specialised hospitals for chest diseases, eye diseases and ear, nose and throat diseases, heart diseases as well as a skin disease infirmary. There are also 12 private clinics in operation in Mauritius. Two mediclinics, 23 area health centres and 108 community health centres are situated all around the island to provide primary health care. The total number of beds in public and private sectors as at the end of 1998 in Mauritius was 4,170, that is one bed for 271 inhabitants or 3.7 beds for 1,000 inhabitants.

2. Background to the HIV/AIDS Epidemic in Mauritius

The first AIDS case in Mauritius was reported in 1987. As of the end of 1999, 230 cumulative HIV/AIDS cases were reported. Of these, 173 were residents and 57 were non-residents. Among the residents, 115 were male and 58 were female. It was reported that 46 people had already passed away. In conclusion, 127 residents were reported to be living with HIV/AIDS at the end of 1999.

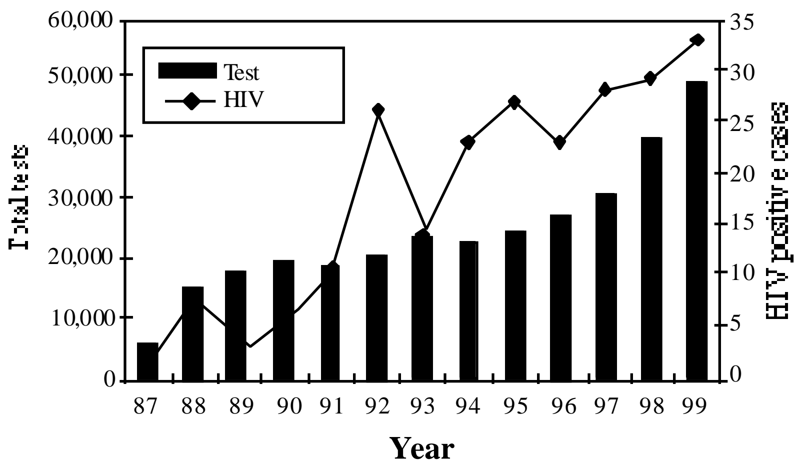


Chart 1 shows the number of HIV tests done and the number of positive cases found in Mauritius by year.

From 1987 to the end of 1999, more than 340,000 HIV tests were done in Mauritius. As is shown by the chart, both the number of the tests and number of positive cases increased gradually in this period.

This can be explained by two reasons. First, improved surveillance detected more cases of HIV/AIDS. The more tests being done, the more positive cases were reported. Another reason is that the incidence itself has increased in these years. It seems that in Mauritius, the epidemic is still at its growing stage and has not yet reached the peak as it has in some other countries.

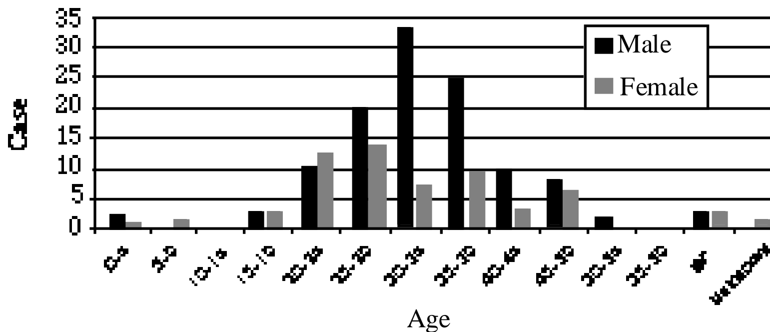
All donated blood has been screened since 1987 and this accounts for some 70% of total HIV tests. The other groups screened are pregnant women, patients who are suspected to have HIV infection, groups of high risk behaviour, people requesting visas for other countries, migrant workers, prison inmates, cardiac patients and their donors and those who voluntarily ask for the test.

On average 20,000 blood donors are tested every year and a few cases of HIV positive were found among them. The HIV prevalence among blood donors ranges between 0% and 0.03%. The screening of pregnant women for HIV with counselling started in September 1998 to prevent mother-to-child transmission using ARV treatment. 0.01% to 0.02% of this group was found to be HIV positive.

Relatively high prevalence is recorded among persons with high-risk behaviour including prison inmates. The most outstanding figure revealed was 7.4% among sex workers in a survey carried out from 1997 to 1998.

In conclusion, we can say that the HIV epidemic in Mauritius is a "concentrated"[1] one. In Mauritius, blood donors are fairly good representatives of the general population because they are from all over the country and are unpaid. Pregnant women are also representative of the general population in their reproductive age. The prevalence of HIV in these groups is below 1%. On the other hand, one specific group, namely female sex workers, recorded a rate of 3.0% to 7.4% HIV positive in the late 90's.

Chart 2: Age/Sex distribution of people living with HIV/AIDS among Mauritians 1987-99 (n=173)



[1] Three stages of HIV Epidemic:

1. Low level epidemic: HIV prevalence has not exceeded 5% in any defined group.
2. Concentrated epidemic: HIV infection continues to be concentrated in highly vulnerable groups and has been recorded at over 5% in at least one of those groups, but in pregnant women, prevalence is below 1%
3. Generalised epidemic: HIV prevalence is higher than 1% in pregnant women.

2.1 *Reported HIV/AIDS Cases among Mauritian Residents*

2.1.1 *Age and sex*

Chart 2 illustrates distribution of all reported HIV/AIDS cases among Mauritians by sex and by age. The age refers to the age when one was found to be positive by test.

More male than female cases were reported. The sex ratio of Male:Female is 2:1. HIV infection concentrates in the age group 15 to 49 years. For female, the peak age is between 20 and 29 years (42%), whereas the peak age for male is 30 to 39 years (49%).Consideration needs to be given to the fact that the age in the Chart 2 is time of detection. It is likely that most of them have been infected earlier. This implies that in terms of prevention of new infections, considerable efforts should be directed to the age group of 10 to 14 years, the age before HIV infection occurs.

Cases under 10-year-olds were secondary to mother-to-child transmission.Since the beginning of surveillance, 18 pregnant women were detected HIV positive and six children were born with the virus.

2.1.2 *Modes of transmission*

The modes of transmission of all HIV/AIDS reported cases among resident Mauritians are classified in Chart 3. Almost 70% of HIV infection occurred through heterosexual contact. Combined with homo/bisexual, more than three quarters of HIV transmission among Mauritians were through sexual contact. Another notable fact is that about 19% of transmission is associated with Injecting Drug Use (2% is IDU only and 17% is heterosexual and IDU combined).

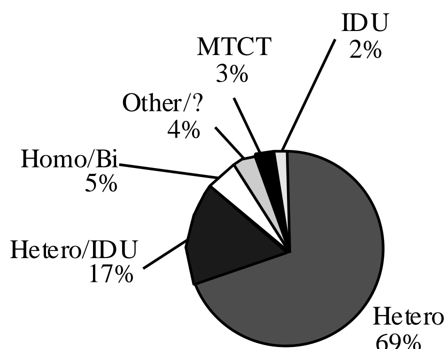
2.1.3 *Occupation*

Among men, 41% were manual workers, namely construction workers, lorry drivers, masons etc. followed by office workers (14%), hotel workers (8%) and businessmen. The rest includes sailors; most of whom make frequent visit abroad.

Among women, housewives account for 56% of the total.The majority of this group was infected by their spouse and detected though partners' notification.The second largest group is sex workers (33%).

This analysis implies that HIV/AIDS has touched various segments of society.

Chart 3: Modes of HIV transmission among Mauritians 1987-1999 (n= 173)



2.1.4 *Origin of Infection*

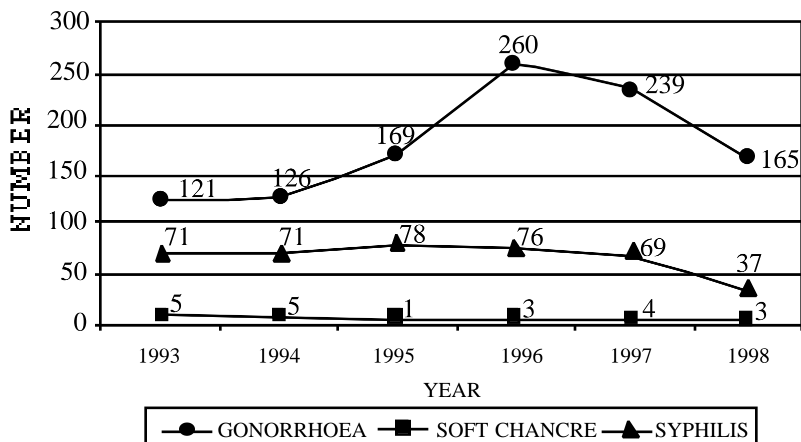
Most reported cases of the late 80's were those infected abroad.The cases infected locally in Mauritius started being reported in the early 90's. It was after 1996 that the local infection exceeded the abroad infection. It seems that towards the end of 90's, the cases infected abroad have stabilised, whereas the local infection is increasing slowly but steadily.

3. Knowledge and Behaviour

Several Knowledge, Attitude, Behaviour and Practice (KABP) studies confirmed that the majority of the general population has heard of AIDS and know several preventive measures for HIV infection. However, it was also found that misconceptions concerning modes of transmission were still strong and complacency was present.

Sex with non-regular partners was reported both in Mauritius and in Rodrigues. Among them, use of condoms was 26.3% in Mauritius compared to 22.0% in Rodrigues (1996). The figure increased slightly since the 1989 KABP study in which 18 to 20% had reported using condoms systematically during casual sex.

In general, the age at first intercourse was reported from 10 to 35 years with a mean of 21.5 years in Mauritius and from 11 to 35 years with mean of 21.5 years in Rodrigues.



4. Sexually Transmitted Infections (STIs)

In 1998, reported cases of major STIs, namely gonorrhoea, soft chancre and syphilis show tendency of decrease (Chart 4). It is known, worldwide, that STIs are underreported. The existence of STIs indicates that some people are still having unprotected sex.

B. RESPONSE ANALYSIS

Currently, major bodies involved in response to HIV/AIDS programmes directly and indirectly are the MOH, NGOs namely PILS and MFPA and other ministries and parastatal bodies such as NATReSA.

1. Activities carried out by MOH (AIDS Division, NDCCI, Virology, Blood Bank)

1.1. *Educational Programme*

The backbone of the National AIDS Control Programme has been educational activities, which lay emphasis on the primary prevention of HIV infection. Target groups are various including medical and paramedical staff, economically dependent women, students in secondary schools, out of school youths and pregnant women in order

to prevent mother-to-child transmission. Particular attention has been paid to certain groups such as sex workers, sailors, injecting drug users, prison inmates and homosexuals. IEC materials have been produced under the responsibility of the Health IEC Unit of the MOH.

1.2. *Prevention of Mother-to-Child Transmission (MTCT)*

Prevention of MTCT is a well-established initiative since 1998. It provides VCT to all pregnant women and AZT to those found positive and to their babies (ACTG 076). Breastmilk substitutes are provided free to these babies for a period of 2 years. The implementation of this protocol is expected to bring down the risk of MTCT to less than 5%.

1.3. *Management of People Living With HIV/AIDS (PLWHA)*

There are presently around 130 notified cases of PLWHA in Mauritius. Many of them are receiving treatment at the NDCCI (National Day Care Centre for the Immunosuppressed), which was launched in December 1999. One doctor trained in HIV/AIDS is attached to this unit and provides medical management (preventive and curative treatment for opportunistic infections) and psychological support to PLWHA. Antiretrovirals (ARV) are available in the MOH for the prevention of mother-to-child transmission of HIV and for the post exposure prophylaxis of HIV for the health care workers.

Counselling and social support are being provided by the doctors and paramedical staff of the AIDS DIVISION / NDCCI.There is need for a social worker to be attached to this department.The country is divided into 5 sanitary regions and in each of these, one nursing staff from the AIDS Division provides counselling to PLWHA and relatives, as well implementing sensitisation programmes.

1.4. *Blood Transfusion Safety*

HIV antibody screening has been mandatory for blood donors since September 1987. Screening is done at the Virology Laboratory along with the serological tests for syphilis, Hepatitis B and C. A few HIV positive cases were detected among blood donors, but no HIV transmission through blood or blood products has been reported so far. In Mauritius, blood donors are not remunerated.They are divided into two main groups; voluntary donors and replacement donors. For

making blood transfusions safer, there is a need to recruit 100% voluntary donors.

2. Activities Carried Out by NGOs

PILS (Prevention, Information et Lutte cotntre le Sida), the first non-governmental organisation (NGO) specifically for the fight against HIV/AIDS in Mauritius, was created in 1996.Funds come mostly from the local private sector. It provides support to PLWHA and conducts information and education campaigns for the general population. Support to PLWHA includes provision of antiretrovirals (ARV) and the patients are under the care of a benevolent doctor. A national campaign for the general population was organised in early 2000 by means of giant posters, leaflets, radio and TV programmes as well as the distribution of condoms.

MFPA (Mauritius Family Planning Association) is the leading non-governmental organisation in the field of family planning, sexual and reproductive health and women empowerment. The advantage of MFPA in response to HIV/AIDS is that it has an immense network and experience in discussion of reproductive health and distribution of condoms. More specifically, MFPA has executed HIV/AIDS education programmes for women workers in the industries. Recently automatic distribution machines for condoms were installed in different places by MFPA.

3. Activities Carried Out by Other Sectors

Ministries and parastatal bodies other than MOH are also active in HIV/AIDS programmes in various ways. Among them is NATReSA (National Agency for the Treatment and Rehabilitation of Substance Abuse), which technically and financially assists the centres for treatment and rehabilitation of substance abusers. There are existing resources and potentials to expand co-operation with the Ministry of Youth and Sports, the Ministry of Women, Family Welfare and Child Development, the Ministry of Education and Scientific Research, the Ministry of Social Security and National Solidarity, the Ministry of Labour, the Ministry of Tourism. The religious bodies are also identified as effective channels to sensitise the population, as they are quite influential over the Mauritians who have strong religious faith.

C. STRATEGIC PLAN

The overall goal of the National AIDS Control Programme 2001 - 2005 is:

"To prevent new HIV infections and to continue caring and supporting people affected by HIV/AIDS in view to reduce morbidity and mortality associated with HIV infection and to minimise its psychosocial impact on individuals and the population at large."

Based on the situation analysis and response analysis of the programme, the following strategic objectives were identified in order to achieve the overall goal (they are prioritised accordingly):

1. Strategic Objectives

1. To generate an environment conducive to effective HIV/AIDS control.
2. To reduce new STI/HIV infection among groups with high risk behaviour.
3. To reduce vulnerability among youths and children.
4. To reduce vulnerability of the business sector and workplace, including the tourism sector.
5. To reduce mother-to-child transmission of HIV.
6. To improve utilisation of Sexually Transmitted Infections Services.
7. To provide care for and support to people infected with and affected by HIV.
8. To reduce nosocomial infection including HIV.
9. To reduce poverty as vulnerability and risk factors of HIV/AIDS.
10. To strengthen surveillance and research.
11. To contribute to the regional co-operation among Indian Ocean countries.
12. To strengthen institutional set-up for management and co-ordination of the national response to HIV/AIDS and proper monitoring and evaluation.

2. Justification

Strategic Objective 1: To generate an environment conducive to effective HIV/AIDS control.

Due to the fact that the HIV prevalence is relatively low in Mauritius, there is a tendency of complacency in the general population. In addition, sex is still considered as a taboo in the society, making open discussion on sexuality - which is inevitable in raising awareness on HIV/AIDS and prevention campaign - more difficult. The KABP survey in 1996 found that the knowledge on HIV/AIDS harboured erroneous ideas, which may constitute the danger of being infected.There is need to create greater awareness and openness on HIV/AIDS in the general population.

Strategic Objective 2: To reduce new STI/HIV infection among groups with high risk behaviour.

Given that the HIV/AIDS epidemic is in a concentrated state, the priority of the programme is the reduction of STI/HIV infection in the highly infected sub-population in order to prevent further spread of HIV in the general population. In Mauritius, sex workers, homo/bisexuals, prison inmates and IDUs are identified as groups vulnerable to HIV infection. More specifically, sex workers are recognised as the most highly infected population, therefore a strong intervention is needed for this group.

- **Sex workers**

  Commercial sex work is not officially recognised in Mauritius but it is present and an important determinant driving the epidemic. Among Mauritian women reported to be HIV positive, 33% were sex workers. In recent years, an HIV infection rate from 3.0 to 7.5% was recorded among sex workers. The KABP study revealed that the mean age at which sex workers started prostitution is 18 years, ranging from 14 to 26 years.

  The absence of official recognition makes it difficult to reach sex workers. In the current programmes, allowances have been given to them when they were involved in the prevention activities. A network has been established with some group leaders to reach the commercial sex workers. The challenge ahead is to overcome the dependency on allowance.

- **IDUs**

  It was found that 19% of known HIV cases are associated with IDU and heterosexual transmission. Though prevalence of HIV among IDUs is unknown, there are needle-sharing practices in this group. This is confirmed by the fact that almost 100% of IDUs are affected with the Hepatitis C virus. More information is needed concerning behaviour of the IDUs in connection with the risk of HIV transmission. However, for the sake of reducing HIV transmission among IDUs, there is a need to advocate for them having easy access to sterile syringes and needles.

- **Men having sex with men**

  Homosexuality is becoming partially visible in Mauritius, though the majority of men having sex with men remain underground.There is no legal or institutional framework enabling the creation of organizations

grouping the men having sex with men. To date about 6% of the total cumulative reported HIV cases in Mauritius are men having sex with men. HIV infection remains a threat to this community.

An established network of peer educators covers the whole island and proves essential in reaching more homosexuals. Presently, the allowance given to them helps enormously in the performance of the activities.

- **Prison inmates**

  The prisons of Mauritius cater for about 1,800 inmates added to two remand centres with a high turn over and mobility. Most inmates are of high-risk behaviour consisting of a high percentage of IDUs and sex workers. The prevalence of HIV among prison inmates is relatively high as compared to the general population.

Strategic Objective 3: To reduce vulnerability among youth and children.

In 1999, 26% of the population was aged between 10 and 24 years. By the end of 1999, about 16% of HIV positive cases were reported among those aged 15 to 24 years. This indicates that actual infection occurred even earlier than these ages since these are the ages when infections were confirmed by test and reported. Generally, earlier first sex encounters had been observed. According to the KABP study carried out in 1996, the age at first intercourse ranges from 10 to 35 years, with the highest cases among the 15 to 19 year age bracket. Furthermore, the age of marriage has been postponed in recent years: 24.8 years for women and 29.6 years for men. Consequently more young people indulge in pre-marital sex, either with casual partners or sex workers. It is crucial to provide information to children before they become sexually active. However, the National Youth Policy covers only those aged above 15 years. Policy on sex education for those aged between 10 and 15 years needs to be created.

The level of education of all reported HIV/AIDS cases is as follows: Primary: 59.2%; Secondary: 28.9%; Tertiary: 2.5%. All levels were affected but those with lower educational levels seem to be more vulnerable to HIV infection than others. However, school dropouts have not been well targeted in the current activities.

Strategic Objective 4: To reduce vulnerability of the business sector and workplace, including the tourism sector.

Lessons learnt from other countries suggest that the business sector is vulnerable to the HIV epidemic. The working population is the productive group in society, but some workers tend to be customers of sex workers. Once the working population is affected by the epidemic, its impact becomes adverse to the family and society at large as well as the economy of the country. Early intervention is crucial to mitigate such impact.

Mauritius is not exceptional in this sense. Among HIV/AIDS reported cases of male Mauritians, 41% are manual workers, 14% office workers, 8% hotel workers, 7% business men, and 7% are sailors. The recent outstanding economic growth has accelerated the mobility of people both in and out of the country in forms of business, migrant work, or tourism. As a result, more people are placed in the situation where they might be exposed to the risk of infection. The tourism sector, one of major growing industries of the country, is considered to be highly vulnerable to the HIV epidemic since tourists are likely to use sex work services.

In the current programme, manual workers have not been addressed adequately. Sensitisation at the workplace, especially in the tourism sector, should be considered a priority area for intervention.

Strategic Objective 5: To reduce mother-to-child transmission of HIV.

The primary prevention of mother-to-child transmission is to protect women of childbearing age from becoming infected with HIV in the first place. With this in view, it is proposed that a holistic approach to reduce the vulnerability of women be combined with the intervention to reduce mother-to-child transmission.

The sex ratio of reported HIV cases among Mauritians is about 2:1.Though reported cases of women are less than those of men, experience in Africa proves that it can be overcome in a short period in a place where heterosexual transmission is the major mode of the transmission. Special attention needs to be given to address the vulnerability of women not only in the biological context but also in the socio-cultural context.

The prevalence of HIV among pregnant women is between 0.01 and 0.02%. It is expected that 4 to 6 of 20,000 pregnant women annually will be HIV-positive.

Strategic Objective 6: To improve utilisation of Sexually Transmitted Infections Services.

It is recognised from evidence-based studies that the existence of a common STI increases the risk of HIV transmission. It is thus important to diagnose and properly treat all cases of common STIs.

According to the health statistics, reported cases of syphilis are decreasing whereas figures of cases of gonorrhoea seem erratic, and there is no definite trend in one way or another. It is well known that figures concerning STIs are underreported.

STIs are presently being treated at the specialised Social Hygiene Clinic, and in dermatology and venereology out-patient departments in regional hospitals. There is need to decentralise STI services to other health settings.

Strategic Objective 7: To provide care and support to people infected and affected by HIV.

Presently around 130 people are known to be living with HIV/AIDS in Mauritius, of whom only 80 are under treatment at the National Day Care Centre for the Immunosuppressed (NDCCI), presently based at Bouloux Area Health Centre, Cassis. Infection with HIV causes a chronic disease with a long asymptomatic phase needing regular medical management to extend the length and improve quality of life.

Strategic Objective 8: To reduce nosocomial infection including HIV.

It is important to reinforce infection control and use of universal precautions to prevent the transmission of nosocomial infections including HIV among patients and health personnel.

For the safety of blood transfusions, HIV anti-body screening is mandatory among blood donors since September 1987. A few HIV positive cases were detected among blood donors, but no HIV infection through blood or blood products has been reported.

Committees for the prevention and management of nosocomial infection were established in regional hospitals in 1998, but they are not functioning efficiently and need to be reinforced. Antiretroviral (ARV) is available for the post exposure prophylaxis of HIV for the health care workers.

Strategic Objective 9: To reduce poverty as vulnerability and risk factors of HIV/AIDS.

It is identified that poverty is the root cause of the HIV/AIDS/STI epidemic since it drives people into an environment or situation where the risk of infection is high. In the economically deprived areas, it is known that activities such as commercial sex work and injecting drug use are more common than in other areas. By combating poverty, it is aimed to reduce chances that people indulge in high risk behaviour, hence to prevent the spread of HIV/AIDS in the long term.

Strategic Objective 10: To strengthen surveillance and research.

HIV/AIDS surveillance and research on specific topics helps to monitor the trend of the epidemic, highlighting past successes and failures and future challenges. In Mauritius, epidemiological data concerning HIV/AIDS is recorded at the virology department and AIDS Division and reported to the Statistical Department of the Ministry of Health. Three KABP studies on AIDS were conducted in 1989, 1992 and 1996. The MFPA conducted a study on HIV/AIDS risk behaviour among young unmarried workers of the industrial sector in 1993. There is also the Youth Profile focusing on youth sexuality compiled by the Ministry of Youth in 1997. Currently the Ministry of Women is conducting a study on sexual exploitation of children.

Strategic Objective 11: To contribute to the regional co-operation among Indian Ocean Countries.

Sub-Saharan Africa is the global epicentre, being home to nearly 70% of global infection by HIV/AIDS and 90% of death from AIDS. Southern Africa turned out to be the world's hardest hit area, where in seven countries, at least one adult in five is living with the virus. However, Mauritius as well as the other Indian Ocean countries namely Seychelles, Comores, Reunion and Madagascar appears as a noticeable exception to the severe epidemic affecting the main continent. There are commonalties among these countries that may be either opportunities or obstacles in response to the AIDS epidemic. It is worthwhile to share specificity of the Indian Ocean countries so that the opportunities will be strengthened and obstacles will be tackled by co-operated efforts.

Strategic Objective 12: To strengthen institutional set-up for management and co-ordination.

Participation of all sectors is the key element of the new national strategic plan. Its implementation requires commitment of all sectors involved and a strong body, which leads in management and co-ordination of the dynamic process. Another key factor is flexibility. The plan will be modified based on constant monitoring of the HIV situation and impact assessment of the programme. The institutional framework needs to be strengthened to meet these requirements.

D. INSTITUTIONAL FRAMEWORK

1. The National Strategic Plan establishes a set of actions that will guide us in the fight against the scourge of HIV/AIDS. Immediate action, motivation to move forward and commitment are essential if the goals are to be met by year 2005.
2. The management of the Plan is primarily the responsibility of the Ministry of Health and Quality of Life but is nevertheless also dependent on a wide range of government institutions, non-governmental organisations, the private sector and civil society.
3. Accordingly, the responsibility for ensuring the implementation of the Strategic Plan from a holistic and integrated approach will rest at a high level.
4. An enhanced framework to support strategic partners in their respective comprehensive but integrated roles and responsibilities, and to follow up on and assess the plan, will be developed taking into account the available structures, facilities and resources.

The National AIDS Committee (NAC)

5. The NAC will be revitalised, reformed and renewed.It will be the highest multi-sectoral body for the HIV/AIDS issue making recommendations on HIV/AIDS policies to the Government, ensuring implementation of the projects, programmes and activities of the strategic plan and other policies, and liaising with financial stakeholders at national, regional and international levels to ensure availability of sufficient resources to achieve the targets set.
6. The NAC will be chaired by the Deputy Prime Minister and Minister of Finance and will comprise:

- Minister of Health and Quality of Life;
- Minister of Social Security, National Solidarity and Senior Citizen Welfare and Reform Institutions;
- Minister of Local Government and Rodrigues;
- Minister of Tourism;
- Minister of Public Infrastructure, Land Transport and Shipping;
- Minister of Labour and Industrial Relations;
- Minister of Women's Rights, Child Development and Family Welfare;
- Minister of Foreign Affairs and Regional Co-operation;
- Minister of Education and Scientific Research;
- Minister of Arts and Culture;
- Minister of Economic Development, Financial Services and Corporate Affairs;
- Attorney General and Minister of Justice and Human Rights;
- Minister of Youth and Sports;
- A representative of the Prime Minister's Office;
- Representatives of NGOs: PILS, MFPA and Action Familiale.

Multi-Sectoral Technical Advisory Committee (MTAC)

7. A MTAC comprising partners who contributed towards the formulation of the Strategic Plan will be set up on a permanent basis, at least until 2005. It will be responsible primarily to suggest and recommend plans of action within the strategic framework (including ways and means of mobilising resources). It will also advise the NAC on issues relating to HIV/AIDS, in particular identify any emerging symptoms prone to positively or negatively affect the situation so that objectives and activities may be reviewed accordingly.

8. NGOs, grass root organisations, trade unions, employees' funds, the private sector and civil society have specific but crucial roles in creating the appropriate climate and environment for implementing activities, particularly those usually encountering resistance. Their representatives will be on the MTAC.

9. All the sectors/partners involved in the implementation of the programmes and projects will be responsible for their monitoring.They will thus be members of the MTAC where they will report on the monitoring status of their respective programmes and projects.

10. The MTAC will meet regularly, at least biannually, to review the current situation and make appropriate reports/recommendations to the NAC.

AIDS Secretariat

11. The AIDS Division of the Ministry of Health and Quality of Life will be strengthened to operate as a fully-fledged AIDS Secretariat. It will be based under the Ministry of Health and its role will be manifold.

12. It will provide secretarial facilities to the NAC and be the link between the MTAC, the NAC and the other stakeholders/partners and the NAC.

13. The AIDS Secretariat will also ensure that the implementing agencies such as the Ministry of Youth and Sports, Ministry of Women's Rights, Ministry of Education, MFPA, AF, PILS etc. are in fact implementing their respective activities under the Strategic Plan. For this purpose, the Secretariat will have regular consultative meetings with each implementing body. Problem areas, if any, will immediately be brought to the NAC for decisions.

14. The Secretariat will, as an executing arm of the Ministry of Health and Quality of Life on the HIV/AIDS issue, implement activities defined under the responsibility of the Ministry of Health and Quality of Life in the Strategic Plan.

15. The Secretariat will, at the end of each year, evaluate the extent of the programme covered in the current year and refer its report to the MTAC for confirmation of findings and advising on actions to be taken to redress shortcomings, if any.

16. The report will thereafter be examined by the NAC for appropriate recommendations to Government.

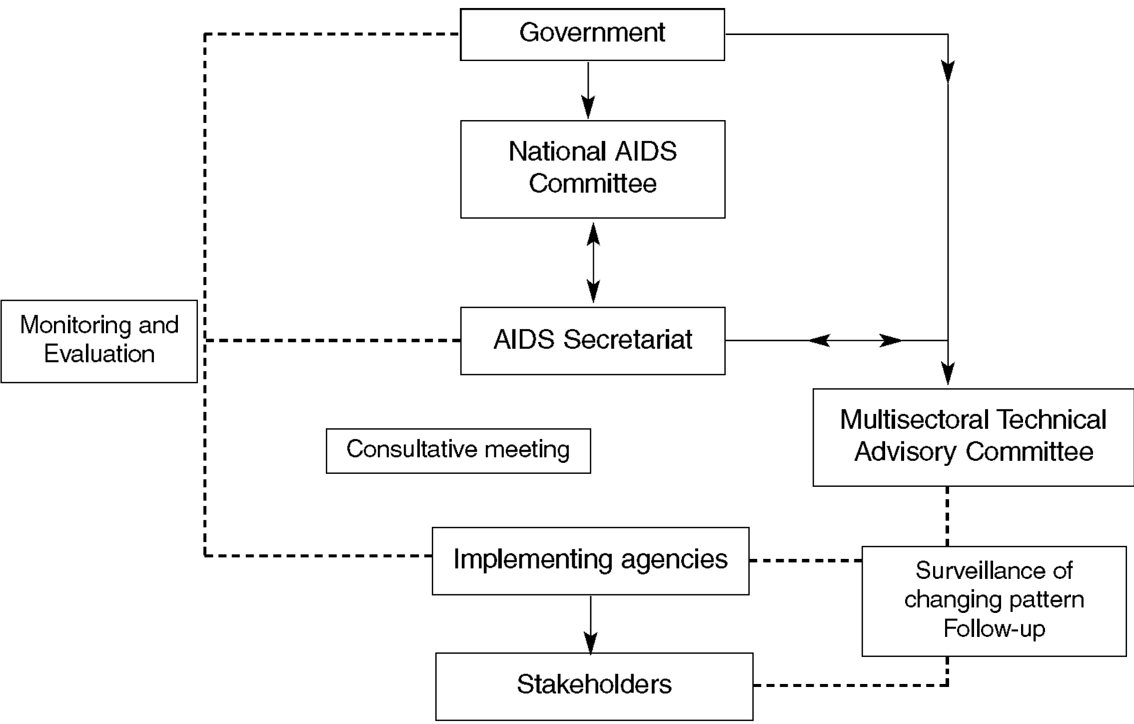
17. At the end of year 2005, the Secretariat will be responsible to carry out a final evaluation to examine the extent to which the priority areas have been addressed and the impact of the programme on the epidemic. However, the NAC can decide if a mid-way report may be necessary for addressing the actual impact of the programme.

E. FINANCIAL ARRANGEMENTS

1. Financial and human resources have generally been major constraints in implementing any plan. Accordingly, the scarcity of resources - human, financial, material and technological - have been taken into consideration in the formulation of the National Strategic Plan.

2. Focus has been laid on the identification and possibilities of opportunities and entry points in the implementation of the plan. However, these opportunities and entry points will have to be further exploited and expanded.
3. Consideration for the integration of the HIV/AIDS activities within the functions of different sectors has been given and has to be further strengthened with a view to minimising the burden of overhead costs.
4. Investments now in HIV/AIDS programmes have an accelerator effect on the nation's savings in the future as is the case for all preventative programmes. But here the effect may be more consequent.The primary responsibility for implementing the National Strategic Plan should, therefore, rests with Government.
5. To achieve these objectives, Government, in addition to providing its usual goods and services, will through the NAC and the AIDS Secretariat, make every effort to systematically seek and mobilise financial resources in particular. However, the first initiative should be the provision of an appropriate budget item for the purpose.
6. Government should encourage NGOs, the private sector, civil society and other institutions, through tax and other relief schemes, to mobilise additional resources for the strategic plan.
7. Support from friendly countries, donor agencies, business associations and institutions should be sought at regional and international levels.
8. The UN Agency should, within its existing mandate, assist in the mobilisation of funds as well as other resources.
9. All funds mobilised shall be managed by the AIDS Secretariat within the framework of the financial management manual and government policies. The latter shall monitor their efficient and effective uses in the implementation of the programmes, projects and activities and report regularly on the financial status to the NAC.

INSTITUTIONAL FRAMEWORK



CASE STUDY:

Combating HIV/AIDS in Namibia
Hon. Elia Kaiyamo MP

It is indeed a great honour to be given the opportunity to address this gathering on the burning issue of HIV/AIDS. Countries all over the world have experienced the devastating effects of HIV/AIDS, and Namibia is no exception.

The country is seriously affected by the HIV/AIDS epidemic, as AIDS has become the main cause of death, especially among young people. Only four cases of the disease were first diagnosed in 1986, but the rate of infections has increased to alarming proportions ever since. According to the latest figures released by the National AIDS Co-ordination Programme (NACOP) of the Ministry of Health and Social Services, about 96,719 Namibians were infected with the disease by the end of October 2001.There is no indication that the rate of infections is going to decrease in the foreseeable future, as we are dealing with a disease that lies low for up to 10 years before it shows its symptoms.

The biggest threat that HIV/AIDS poses is the fact that it targets the economically active sector of the population; those between the ages of 20 and 50 years. The disease is therefore not merely a health problem, but also a developmental one. Combating the spread of HIV/AIDS is a costly affair. The costs involved centre around expenses on AIDS testing, awareness campaigns, treatment, etc.

Namibia is losing an increasing number of young people. Although it is very difficult to get accurate figures on the prevalence of the disease, indications are that there is a high occurrence amongst pregnant women countrywide. The death of parents as a result of AIDS increases the problem of street-children with no parents to look after them.Those that die are often the sole breadwinners of a family.

A crucial aspect of the fight against HIV/AIDS is the prevention of new infections. It is deplorable that after years of campaigning for the use of condoms, there are still people who do not resort to this safety method.I am happy to announce my satisfaction with the latest advertisement technique produced by the Ministry of Health and Social Services. This technique is about setting up billboards all over the country saying ‘AIDS is Real’, and showing the number of people who have been infected, the number

hospitalised and the number who died.It is necessary that the whole society be sensitised to have sympathy with HIV/AIDS patients.

Government officials in general and parliamentarians in particular are to be at the forefront of the fight against this killer disease. In our society, political leaders, as newsmakers, have ample access to the news media. They should therefore make use of this opportunity to educate the society about HIV/AIDS. Parliaments should hold special sessions on HIV/AIDS and ensure that such sessions are widely covered by the media. It is very important that every citizen knows exactly what the disease is all about and about how to prevent getting it. People, especially the sexually active ones, must be encouraged to carry condoms the same way they would carry handkerchiefs, just in case of need.

The fight against HIV/AIDS is made difficult by other social evils like alcohol and drug abuse. People get drunk and forget or neglect to use condoms. Very often, condoms are not available at the nightclubs and shebeens where people gather late into the night.

The multi-sectoral approach adopted by the Namibian government in combating HIV/AIDS is a commendable one. It is based on the premise that the involvement of everybody concerned is necessary in order to put up an effective fight. Even though it is the Ministry of Health and Social Services that directly deals with HIV/AIDS cases, the call goes out to all sectors of society to become more actively involved in the fight against HIV/AIDS. The churches, employers, traditional leaders and community organisations are well positioned to play a bigger role in the education of citizens. It is no use shying away from discussing HIV/AIDS whenever possible. The consequences of silence will affect everyone, directly or indirectly, one way or another. People living with the disease must be in a caring, understanding environment both at home and at work. The society must be educated not only to accept people living with the virus but must also know how to care for them.

This gathering is obviously going to play its part in continuing the struggle against HIV/AIDS. The challenge however, is for what will be decided upon by this gathering to reach the ears of those who need information the most, namely, those in the remotest areas of our countries.

CASE STUDY:

HIV and AIDS in South Africa

1. Introduction

HIV prevalence is growing at an alarming rate in South Africa. According to the South African Health Review (2000), from 1990 to 1998, there had been a 32-fold increase in HIV infection rates, with a slight flattening in 1999.The statistics to follow indicate that HIV and AIDS primarily affect working-age adults. It reportedly far outweighs any other threat to the health and well-being of South African employees.

This paper briefly outlines the nature of the epidemic in South Africa, the impact that it has, treatment issues as well as Government's awareness campaigns.

2. HIV and AIDS Statistics

Statistics regarding HIV and AIDS infections in South Africa are not very reliable. AIDS is not a notifiable disease in South Africa and voluntary reporting seriously underestimates the number of people living with AIDS. Statistics regarding HIV and AIDS infection in South Africa are therefore estimated, based upon the National HIV sero-prevalence survey of women attending public antenatal clinics[2]. However, as 85.2% of the pregnant women who attend antenatal clinics are African, the results of the survey reflect an under-representation of women from race groups other than African.

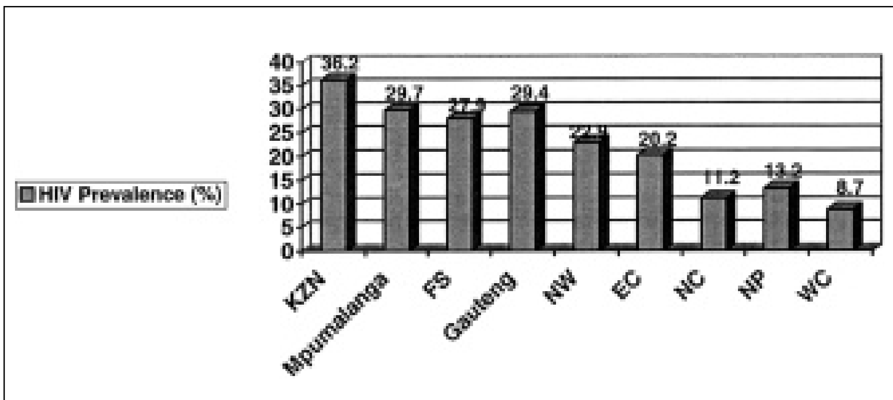
Also, the survey results are only able to give direct estimates of HIV infection among (pregnant) women and thus exclude reliable information for the population of men, children and women (who are not pregnant). Projections to the general population are therefore made to extrapolate the total number of persons who have been infected in 2000. As stated by the researchers of the antenatal survey, the number of people infected needs to be viewed with caution because of the limitations in the methodology applied. Estimates suggest that approximately 1 in every 9, or an estimated 4,7 million South

[2] The antenatal survey prevalence figures do not reflect the lower overall risk of men, people who are sexually active and communities using the private sector. Recent studies also indicate that fertility among HIV positive women is substantially lower than among uninfected women, in all but the youngest age groups and this suggests that antenatal data may in fact underestimate HIV prevalence in women of reproductive age in many countries (loveLife, 2001).

Africans were infected with HIV by the end of 2000. A closer breakdown reveals the following:

Women (15 to 49 years)	2.5 million
Men (15 to 49 years)	2.2 million
Babies	106,109
Total South Africans	4.7 million

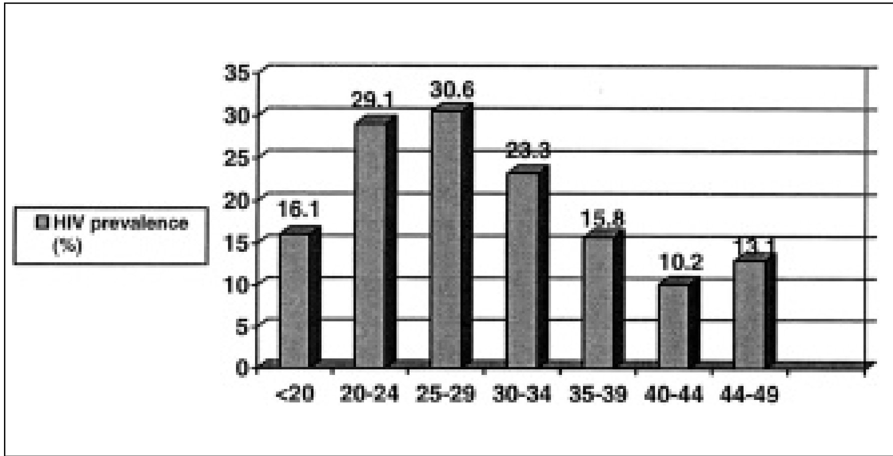
- **Provincial HIV Estimates**



The provincial trends indicate that the epidemic varies across the different regions in South Africa and that it is in different stages in the different parts of the country. KwaZulu-Natal remains the province with the highest prevalence. It is important to note that the Western Cape, with the lowest prevalence, has shown an increase from 5.2% in 1998 to 8.7% in 2000.The North-West is the only province where a decline in prevalence has been observed, while in the Free State it remained the same. In relation to the other provinces, prevalence in the Eastern Cape is towards the lower end of the spectrum.

- **HIV Prevalence by Age**

The graph indicates that women in their 20s continue to represent the group with the highest number of individuals who have HIV infection. The results show that there has been a decline in the infection rate among women younger than 20 from 21% in 1998, 16.5% in 1999 to 16.1% in 2000. This



is consistent with other findings that have reported that condom use is higher amongst female teenagers. However, of concern is the rise in the infection rate among women in their 20's.

3. Why is HIV and AIDS so widespread in South Africa?

A number of reasons can be postulated for the extensive spread of HIV and AIDS in South Africa. The Government's HIV/AIDS/STD Strategic Plan indicates that the immediate determinants of the epidemic include behavioural factors such as unprotected sexual intercourse and multiple sexual partners and biological factors such as the high prevalence of sexually transmitted diseases (STDs).The underlying causes include socio-economic factors such as poverty, migrant labour, commercial sex workers, the low status of women, illiteracy and the lack of formal education, stigma and discrimination.

A UNDP report on HIV/AIDS and Human Development in South Africa also identifies migration as a major factor in the spread of HIV and other sexually transmitted diseases in South Africa. This is supported by a UNAIDS and United Nations Research Institute for Social Development (UNRISD) report (2000) which further identifies poverty-driven sex-work as another contributory factor to the spread of HIV and AIDS. Both migration and sex-work place men and women in high risk situations, in which institutions providing support for stable family relations are absent.

Women are also particularly vulnerable to HIV and AIDS. This stems from a range of social, economic, biological, cultural and legal factors. Biologically, women are more vulnerable to HIV infection than men. During unprotected sex, the risk of HIV infection is 2 to 4 times higher for women than men due to women's physiology.

Violence against women and forced sex also contribute to the risk of HIV infection. These occur in the following ways[3]:

i. Rape may increase the risk of women and girls contracting HIV. Typically, rape does not occur in circumstances where a condom will be used. Furthermore, the violent nature of rape creates a higher risk of genital injury and bleeding (increasing the risk of HIV transmission), while in the case of gang rape, exposure to multiple assailants may also contribute to the increased risk of transmission.

ii. Abusive relationships may limit women's ability to negotiate safer sex.

iii. Women who have a history of childhood sexual abuse may engage in riskier sexual behaviour as adolescents or adults, increasing their risk of HIV infection.

iv. Women who receive HIV counselling and testing may be at risk of partner violence should they disclose their HIV status.

The Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women's report on 'How best can SA address the horrific impact of HIV/AIDS on women and girls?' amongst others, strongly recommends that the Government's HIV/AIDS/STD strategy recognises that sexual inequality is driving the spread of the epidemic.Public education campaigns thus have to show how sexual inequality, violence and the rape-of-the-virgin myth are contributing to the spread of HIV and AIDS.

4. Impact of HIV and AIDS

As the HIV and AIDS epidemic is evolving, one of the most striking features is its profound link to poverty. This is of grave concern as statistics have also shown that 65% of individuals living in the Eastern Cape are poor. HIV and AIDS contribute to households and individuals becoming poorer and lower

[3] Mamam et al (2000) quoted in the report by the Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women on 'How best can SA address the horrific impact of HIV/AIDS on women and girls?', November 2001.

the level of health in communities because of its relation to other diseases such as tuberculosis (TB). It is those who are most afflicted by poverty who are most infected with and affected by HIV and AIDS. It is clear that the South African epidemic is predominantly one of the lower socio-economic groups made up largely of poor black women and men. A concerted response is required to combat the devastating social and economic consequences of HIV and AIDS in the South African society.

HIV and AIDS also impacts on society in the following ways:

i. Average life expectancy will fall from 60 to 40 years between 1998 and 2008.

ii. Infant mortality will rise from 50 per 1000 to more than 60 per 1000 between 1998 and 2008.

iii. It is estimated that by 2005, 1 million children younger than 15 will have lost their mothers to AIDS. The number of AIDS orphans will have increased to 2 million by 2010.

iv. The rapid increase in HIV infections amongst young women has implications for the increase in the rate of vertical transmission of HIV to children.

v. The burden on women as care givers increases as they have to care for those affected by HIV and AIDS. With the rate of women infected increasing as it is, the consequences become even more profound.

vi. The impact of HIV and AIDS will be most evident in the health sector with HIV estimated to consume a large proportion of the health budget in future. The impact of HIV and AIDS has already been felt in public hospitals such as Red Cross Hospital in Cape Town where 20% of the children are HIV positive (South African Health Review, 1999).

vii. HIV and AIDS are putting increasing strain on provincial budgets, according to the latest Intergovernmental Fiscal Review released by the Treasury Department.This impacts severely on the ability of provinces to deliver services.

viii. Provinces such as KwaZulu-Natal report that close to 40% of patients in medical wards are HIV positive. The demand for health care has increased substantially, as well as the treatment for diseases such as malaria and tuberculosis, which is made substantially more expensive by the HIV and AIDS epidemic.

ix. A Medical Research Council Report[4] (2001) on the impact of HIV and AIDS on the mortality rate in South Africa indicated that:
   - The mortality rate of young, adult women between 25 and 29 years of age has increased rapidly with the mortality rate in 1999/2000 being 3.5 times higher than in 1985;
   - Approximately 40% of adult deaths aged 15 to 49 in 2000 were due to HIV and AIDS;
   - About 20% of all adult deaths in 2000 were due to AIDS;
   - Together with the excess deaths in childhood, it is estimated that AIDS accounted for about 25% of all deaths in 2000 and has become the single biggest cause of death;
   - Projections show that without treatment to prevent AIDS, the number of AIDS deaths can be expected to grow to more than double the number of deaths due to all other causes, resulting in 5 to 7 million cumulative AIDS deaths in South Africa by 2010.

5. Approaches to Reduce HIV and AIDS

HIV and AIDS have claimed millions of lives globally and caused a global crisis. To address the epidemic, it would require action not only from individuals, but concerted and co-ordinated action from communities, nations and regions collectively. The best global response to AIDS has shown the need for leadership, teamwork and partnerships.

An HIV/AIDS and STD Strategic Plan for South Africa for the years 2000 - 2005 has been developed. The document serves as a broad national strategic plan designed to guide the country's response to the epidemic. Although initiated by the Department of Health, it is a plan that cuts across departments and is a statement of intent for the whole country, inside and outside government. It is envisaged that the document be used as a basis for other organisations, departments and stakeholders to develop their own strategic plan.

The primary goals of the plan are to:

i. Reduce the number of new HIV infections (especially among the youth);

ii. Reduce the impact of HIV and AIDS on individuals, families and communities.

[4] This report was criticised by Government.One of the criticisms levelled against it was that it formed part of a bigger study looking into HIV and AIDS mortality.

This will be achieved by adopting the following strategies:

i. Implementing an effective and culturally appropriate information, education and communications (IEC) strategy;
ii. Increasing access and acceptability to voluntary HIV testing and counselling;
iii. Improving STD management and promoting increased condom use;
iv. Improving the care and treatment of HIV positive persons and persons living with AIDS. In this way, a better quality of life will be promoted and this should limit the need for hospital care.

The plan focuses on four areas including prevention; treatment, care, and support;human and legal rights;monitoring, research and surveillance. With regard to prevention, activities considering the following goals should be undertaken:

i. Promoting safe and healthy sexual behaviour;
ii. Improving the management and control of STD's;
iii. Reducing mother-to-child transmission;
iv. Addressing issues relating to blood transfusion and HIV;
v. Providing appropriate post-exposure services;
vi. Improving access to Voluntary HIV Testing and Counselling (VTC).

In April 2000, Cabinet endorsed a decision to invite an international panel of experts to South Africa and provided a platform for them to deliberate on the issues pertaining to HIV and AIDS. The panel was composed of experts who supported the notion that HIV caused AIDS as well as AIDS dissidents. The Presidential AIDS Advisory Panel Prevention of AIDS recommended the following prevention measures from the point of view of panelists who do not support the causal link between HIV and AIDS[5]:

i. Improving sanitation and public health measures to decrease water-borne diseases;
ii. Strengthening health infrastructure;
iii. Reduction of poverty and improving general nutrition and implementing nutritional education and supplements for the general population;
iv. Improving screening for and treatment of sexually transmitted diseases;

[5] Extract from the Presidential AIDS Advisory Panel Report, Pretoria, March 2001.

v. Promoting sex education based on the premise that many sexually transmitted diseases and pregnancies could be avoided;
vi. Implementing public education campaigns to destigmatise AIDS and reduce public hysteria surrounding the disease;
vii. Investigating the use of immune-boosting medication;
viii. Encouraging the detoxification of the body through several inexpensive interventions, such as massage therapy, music therapy, yoga, spiritual care, homeopathy, Indian ayurvedic medicine, light therapy and many other methods;
ix. Treating infections vigorously and timeously;
x. Increased support for and promotion of research into the development of drugs against AIDS, its co-factors and risk factors;
xi. Encouraging the involvement of complementary medical and health practitioners, including indigenous healers, in research and clinical practice;
xii. Implementing aggressive programmes to empower women and change the power relations between men and women;
xiii. Reducing the vulnerability of communities by improving access to health care;
xiv. Improving literacy.

With regard to the prevention of HIV and AIDS, the panelists who support the causal link of HIV and AIDS raised several strategies. These panelists proposed that preventive strategies be linked specifically to the different modes of transmission of HIV/AIDS. These included, through sexual transmission, blood-borne transmission of HIV and through mother-to-child transmission.

Furthermore, the HIV/AIDS and STD Directorate in the National Department of Health released a set of HIV/AIDS policy guidelines in August 2000. These guidelines cover a range of issues related to the treatment and management of HIV and AIDS. These include guidelines on:

i. The prevention and treatment of opportunistic and HIV related diseases in adults;
ii. Tuberculosis (TB) and HIV/AIDS;
iii. Feeding of infants of HIV positive mothers;

iv. Prevention of mother-to-child HIV transmission and management of HIV positive pregnant women;
v. Managing HIV in children;
vi. Ethical considerations of HIV/AIDS clinical and epidemiological research;
vii. Management of occupational exposure to HIV;
viii. Testing for HIV;
ix. Rapid HIV testing.

In the TB and HIV/AIDS guideline, it can be observed that TB can be cured whether a patient is living with HIV or not. This is done by using the Directly Observed Treatment Short-course (DOTS), using the same drugs and the same amount of drugs. However, the debate in the public sphere has mostly focused on the availability of antiretrovirals in the public sector. In the introduction to the guideline on the Prevention and Treatment of opportunistic and HIV related diseases in adults, it is stated that guidelines for the use of antiretrovirals are not included. When the guidelines were published, antiretrovirals were not being used in the public sector.

A Department of Health report (July 2001) states that the department is considering the development of an enhanced response to the epidemic. The approach identifies four focus areas: prevention; treatment, care and support; tuberculosis control and programme management. Interventions in these focus areas are then grouped into 3 categories namely:

i. Core interventions - interventions of proven effectiveness and cost-effectiveness that can be adopted or expanded with confidence. Examples are improved availability of essential drugs and home-based care.

ii. Lower cost / higher certainty interventions - these are interventions for which there is less evidence than for the core package but which shows promise pending the outcomes of current research. Examples include the roll-out of the prevention of mother-to-child transmission pilot programme, which is being tested throughout the country. Provinces are currently scrutinizing the reports from the research sites and consulting with the aim of formulating a response based on the national protocols. This process will guide policy direction. Kwazulu-Natal and Gauteng have already indicated that they are in a position to roll-out the mother-to-child transmission programme without delay.

iii. Higher cost / lower certainty interventions - these are interventions which have significant cost implications and which require substantial further research before adoption. Policy relevant responses will be required for this in the medium term. Examples are the affordability and effectiveness of antiretroviral therapy in the South African public health sector.

Other effective interventions mentioned by the Department include home-based care and step-down-care for people with AIDS. These are geared towards achieving the following:

i. Diverting increased demand for care from acute hospitals and into a lower cost environment, allowing the hospitals to focus on patients requiring more complex care;

ii. A low cost and flexible option for expanding service provision in areas which are currently under-served.

6. Government's Awareness Campaigns

The Government has adopted the A-B-C strategy - Abstain, Be Faithful and use Condoms - as a core message in its public communication. This strategy has been criticised by various sectors presenting at the public hearings held by the Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women in 2001. The hearings heard that women who try to get men to "Abstain, Be faithful and use a Condom" face rejection, beating and even death. The hearings heard that ABC could not work in a context where there are so many socio-cultural barriers to women's sexual autonomy. The Committee therefore recommended that these barriers be addressed urgently.

Another project was the Beyond Awareness Campaign of the HIV/AIDS and STD Directorate of the Department of Health. The campaign ran from November 1998 through to October 2000 and was conducted by a consortium of four organisations - AIDS Media Research Project, DramAidE, Lindsay Smithers FCB and Wireless Additive.

The challenge for the Beyond Awareness Campaign was to develop a campaign that does more than simply raise awareness. Although the Campaign included awareness raising activities, its focus was to provide and promote access to communication tools and resources that could be used in support of prevention, care and support activities and initiatives at local level.

Government is currently contributing R25 million to loveLife for their prevention campaigns targeting young people, which aim to delay early sexual activity and promote safer sex. R8.3 million of the amount contributed to loveLife has been invested in the loveLife (school) games aimed at challenging lifestyle among the youth. loveLife was established in 1999 and aims to reduce the incidence of HIV among 15 to 12 year olds by at least 50% over the next five years. The organisation targets 12 to 17 year olds, focusing on promoting positive sexual health and healthy lifestyles for young people.

Other initiatives being undertaken for 2002 include:

i. A health worker excellence campaign that will target nurses, doctors and traditional healers, encouraging a positive response to HIV and AIDS care and boosting morale amongst health workers;

ii. The promotion of positive living for those with HIV and support for orphans and vulnerable children;

iii. Specific campaigns on sexually transmitted infections and TB.

The above events will all culminate in World AIDS Day on 1 December as a key national rallying point.

7. Conclusion

South Africa has a strategic plan to address the HIV and AIDS epidemic in the country. This plan is supported by, amongst others, the UNAIDS. It has also received criticism from various sectors, that are questioning Government's stance, particularly on the supply of antiretrovirals. There is a need to assess why, with a comprehensive plan in place and a large proportion of national health budget going towards prevention programmes, the prevalence of HIV is so high. We need to take the lessons learnt in others countries, such as Uganda, Senegal, Thailand and Brazil into account and see what it is that South Africa is not doing or needing to do differently. There is also a need to assess the intervention and prevention programmes of the various departments and that of the Department of Health as considerable amounts of money are already being spent on HIV and AIDS in the country.

REFERENCES

Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women report on 'How best can SA address the horrific impact of HIV/AIDS on women and girls?' November 2001.

MRC Technical Report.The impact of HIV/AIDS on adult mortality in South Africa. September 2001.

Mr B. Makinwa, UNAIDS. Presentation to the Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women, September 2001.

CASE STUDY:

Status Report on HIV/AIDS in Tanzania

1. INTRODUCTION

1.1 Background: General

In the 1980's a new epidemic, AIDS, emerged as a threat to the health, development and survival of millions of individuals, families and communities through out the world.

By early 1992, according to the WHO1 Global Programme on HIV/AIDS, an estimated 9 to 11 million adult men and women worldwide were already infected with HIV, the virus that causes AIDS. WHO went further to argue that women infected with HIV have given birth to about 1 million HIV-infected children. Worldwide the number of adults and children who have already developed AIDS is estimated at about 2 million, many of whom have already died (WHO: 92).

Nowhere in the world is the AIDS situation more critical than in Sub-Saharan Africa. AIDS is the foremost cause of death in Africa.In 1998 more than two million Africans died of AIDS - equivalent to wiping out the entire adult population of Norway in a single year (WB2 Institute Vol. 1 No. 2, 1999).

Though it has just tenth of the world's population, Sub-Sahara Africa is home to two-thirds of the world's HIV-positive population and in many places HIV is still spreading with the range and speed of a wild fire (ibid).

According to 'The African' (local newspaper of Thursday April 5,2001), the United Nations Economic Commission for Africa (ECA) said that HIV/AIDS has claimed about one million lives in the Sub-Sahara region during the last year. ECA Director Robert Okello said that unless concerted efforts are put in place to fight the deadly disease, progress would continue to be threatened in the region. He went further arguing that the deadly disease has proved to be a calamity in the Sub-Sahara region as it has not only affected families but also the economies of Africa.

Peter Plot in 'Development Outreach' (Vol. 1 No. 2, 1999) says that AIDS in Africa is more than an epidemic; it is a massive development catastrophe, a most infectious disease that kills off the weak - the very young and the very old.He also says that HIV/AIDS targets people in the prime of their working

and parenting lives and that around half of all people who acquire HIV become infected before they turn 25.He further states that they develop and finally die of the illness called AIDS before their 35th birthday. This age factor leaves AIDS uniquely threatening to families, communities and economics (ibid).

According to existing literature, the number of children who lose one or both parents through AIDS is expected to increase more than tenfold during the current decade. Literature estimates that by the year 2000 between 10 and 15 million AIDS orphans would be found worldwide, most of them in Sub-Sahara Africa. In parts of East and Central Africa child mortality rates which had been greatly reduced over the past few decades are starting to rise again because of AIDS (Chandra: 92.) It is estimated that around 25.5 million adults and more than 2.4 million children worldwide have been infected with HIV since the beginning of the epidemic to the mid 1990s (NACP3: 96).

1.2 Tanzania's Case

In Tanzania, following recognition of the first three cases in 1983, reported cases escalated rapidly, with a cumulative total of 21,175 AIDS cases reported throughout the country at the end of 1990 (Chin and Sonnenberg: 1991).

The National AIDS Control Program (NACP) estimates that the true number of AIDS cases from the start of the epidemic through 1990 is more than 100,000 or about 5 times the number of reported cases.The NACP estimated Tanzania to have 450,000 cumulative AIDS cases until the end of 1996.

Fear to speak about AIDS is a serious problem in our country since the disease affects mainly the sexually active members of the population and infants. For instance, about 94% of all reported cases have been between the ages of 15 and 55 years, and 4% have seen children under five (NACP: 1991). Serious micro economic effects on Tanzanian society are unavoidable.

According to the Tanzania National Policy on HIV/AIDS (2001), after three AIDS cases were reported in Kagera region in 1983, by 1986 all regions in the Tanzania's Mainland had reported AIDS cases. By the end of 1999, there were some 600,000 cases of HIV/AIDS and a similar number of orphans. It is also estimated that over 2 million people are infected with HIV/AIDS, 70.5% of whom are in the age group 25 to 49 years, and 15% in

age group of 15 to 24 years. Over 72,000 newborn babies were infected with HIV. Women are infected at much earlier ages. Among the new infections in women, 69% were in the 15 to 24 age group.

Tanzania is among the countries with high prevalence of HIV. Since the cases were reported, the epidemic has spread relentlessly among people in all walks of life, particularly the most productive segment of the population. Data from selected sentinel surveillance show a two-fold increase in HIV prevalence among female blood donors from 7.2 to 13.3% during the last ten years (1991 - 2000). HIV prevalence among pregnant women attending antenatal clinics for the first time in the year 2000 ranges from 4.2 to 32.1% and 13.3% of women who delivered in health care facilities were HIV positive (NACP Report No. 15). It is estimated that about 12% of adults (15 to 49 years) were living with HIV/AIDS in 2000 (UN AIDS, WHO, European Commission News Letter).

According to a local newspaper (Majira April 7, 2001), 50% of the admitted patients in Muhimbili Medical Centre have been found with HIV/AIDS. That is a scaring number of infected persons in one of the many hospitals found in the country.

Apart from the epidemiological data on HIV/AIDS, little information is available regarding the extent of the epidemic, the status of the national response, and the social and economic impact of the epidemic. Initiatives are underway to collect information on the national response and the impact of the epidemic.

2. NATIONAL RESPONSE TO HIV/AIDS EPIDEMIC

Government observed that this epidemic is not only a health problem, it also touches social and economic sectors from which its outcomes have not only affected the health of the people but also depleted household savings, killed loved ones and affected economic development at large. Therefore in order to mitigate such situations, the government decided to establish programmes and plans committees and fomulated policies. At the outbreak of the epidemic, government with technical support from the World Health Organization-Global Programme on AIDS (WHO-GPA) formed the National AIDS Control Programme (NACP) under the Ministry of Health. This was later re-enforced by the National AIDS Committee (NAC) in 1998, followed by the National Advisory Board on AIDS (NABA) in 1999. Government also formulated short and medium term plans, starting with a short term plan

which lasted from 1985 - 1986, followed by the three 5-year Medium Term Plans (MTP-I, -II and -III) with MTP-III expected to end in 2002.

The national response consisted of developing strategies to prevent, control and mitigate the impact of the HIV/AIDS epidemic, through decentralising multi-sectoral response and community participation. However, these initiatives were constrained by a number of factors including inadequate human and financial resources in effective co-ordination, mechanisms and inadequate political commitment and leadership. Despite the constraints, significant achievements have been made. These are in the areas of blood safety, epidemiological surveillance, management of sexual transmitted infection, Information Education Communication (IEC), laboratory diagnosis and research, voluntary counselling and testing and the prevention of mother-to-child transmission. Some of these constraints are now being addressed. There is strong political commitment and leadership from the highest level. HIV/AIDS is now one of the top priority development agendas in the government along with poverty alleviation, improvement of health, education and other social sector services. Government has allocated US$ 8 million for HIV/AIDS for the 2001/2002 fiscal year and all sectors and districts and municipal councils are implementing HIV/AIDS interventions.

The Tanzania Commission for AIDS (TACAIDS) has been formally instituted to co-ordinate and intensify the national response. The National Policy on HIV/AIDS is now in place. The on-going government reforms are aimed at facilitating people's participation in decision making on issues that affect their lives, including HIV/AIDS at the district level. The high and increasing HIV prevalence and prevailing political and international momentum provide a unique opportunity to intensify the national response and MTP-III provides the launching pad.

2.1 Formulation of National Policies for HIV/AIDS/STDs

In realisation of the seriousness of this AIDS epidemic and apart from formulation of various plans and programmes which jointly could be useful to fight this killer disease, the Government of Tanzania prudently stipulated defined principles and strategies, which regulate the conducts and functions of the mentioned plans and programmes which were created. By doing so, it formulated the national policies on HIV/AIDS/STDs. It started with the National Policy on HIV/AIDS/STDs in 1995 which is under the Ministry of Health, followed by the National Policy on HIV/AIDS in 2001 under the Prime Minister's Office. Among other things, these policies provide for the

principles, guidelines and advocacy strategies towards combating the epidemic.They also mean to regulate the way in which the functions of the organs concerning fighting AIDS are discharged.

The overall goal of these national policies on HIV/AIDS is to provide a framework for leadership and co-ordination of the national multi-sectoral response to the HIV/AIDS epidemic. This includes formulation by all sectors of appropriate interventions which will be effective in preventing transmission of HIV/AIDS and other sexually transmitted infections, protecting and supporting vulnerable groups, mitigating the social and economic impact of HIV/AIDS. It also provides the framework for strengthening the capacity for institutions, communities and individuals in all sectors to arrest the spread of the epidemic. Being a socio-cultural and economic problem, prevention and control of the HIV/AIDS epidemic will very much depend on effective community based prevention, care and support interventions. The local government councils will be the focal point for involving and co-ordinating public and private sectors, NGOs and faith groups in planning and implementing HIV/AIDS interventions, particularly community-based interventions. Best experiences in community-based approaches in some districts in the country will be shared with local councils.

In view of the national response towards prevention of HIV/AIDS/STDs, Government through the national policies for HIV/AIDS/STDs formulated principles to guide the implementation of the programme i.e. MTP-III, namely:

i. Respect for basic human rights and equal protection for all persons is ensured irrespective of age, sex, race political orientation or religion;

ii. Promote the health system responsiveness to the needs of people in Tanzania;

iii. Increase health system responsiveness to the needs of people in Tanzania;

iv. Ensure that health services are available and accessible to all in urban and rural areas;

v. Ensure that all health cadres shall strive to be self-sufficient at all levels from village to national;

vi. Ensure that communities are sensitised on common preventable health problems and empowered to assess, analyse problems and to design appropriate action through genuine community involvement;

vii. Awareness by Government and the community at large that health problems can only be adequately solved through multi-sectoral co-ordination involving public, private as well as the non-governmental sector and religious groups;

viii. Responsibility for one's health rests squarely with the able-bodied individual as an integral part of the family;

ix. Transmission of HIV is preventable through change in individual behaviour while education and prevention programmes are necessary to bring about changes;

x. Each person must accept responsibility for the prevention of HIV transmission through sexual intercourse or sharing of infected needles and provide care and support for those infected and affected by HIV;

xi. The community as a whole has the right to correct information of HIV/AIDS and therefore to appropriate protection against HIV infection;

xii. The law should complement and assist education and public health measures in the prevention of HIV transmission.

2.2 Institutional Mechanism

The institutional framework for the national response is currently in the process of transformation, from the National AIDS Control Programme (NACP) under the Ministry of Health (MoH) to the centrally placed Tanzania Commission for AIDS (TACAIDS) under the Prime Minister's Office. In 1998, government through the Ministry of Health established the NACP which is the institution responsible for the control and prevention of HIV/AIDS/STDs in the country with the following major goals:

i. To reduce further transmission of HIV;

ii. To minimise or mitigate the personal and social impact of the HIV infections.

NACP also co-ordinates the National AIDS Policy. However, due to the multi-sectoral nature of the issues involved, multi-sectoral committees will be created at various levels to co-ordinate the different sectors.

Government recently established the Tanzania Commission for AIDS (TACAIDS), under the Tanzania Commission for AIDS Act 2001. The Act gives the Commission the appropriate mandate and statutory powers to discharge its roles and functions while the policy regulates the way in which these functions are discharged.

The aim in establishing this commission is to affiliate the NACP under the Ministry of Health into TACAIDS. The goal of this Commission is to facilitate strategic leadership and multi sectoral co-ordination, monitoring and evaluation of the national response programme. TACAIDS will neither be an implementing agency nor the channel for funds, save in exceptional cases.

TACAIDS operates as an independent department, which enables it to plan, regulate and control its affairs independently but within the government system.

The roles of the commissions in relation to combating HIV/AIDS are as follows:

i. To formulate policy guidelines for the response to the HIV/AIDS epidemic and management of its consequences in mainland Tanzania;

ii. To promote research information sharing and documentation on HIV/AIDS prevention and control;

iii. To develop a strategic framework for planning of all HIV/AIDS control programmes and activities within the over-all national multi-sectoral strategy;

iv. To foster national and international linkages among all stakeholders through proper co-ordination of all HIV/AIDS prevention and control programmes and activities within the over-all national multi-sectoral strategy;

v. Mobilising, disbursing and monitoring resources and ensuring their equitable distribution where applicable;

vi. Disseminating information sharing on the HIV/AIDS epidemic and its consequences in Tanzania and on the programmes for its control;

vii. Promoting high level advocacy and education on HIV/AIDS prevention and control;

viii. Monitoring and evaluating all on going HIV/AIDS activities;

ix. Co-ordinating all activities related to the management of the HIV/AIDS epidemic in Tanzania as per national strategy;

x. Facilitating efforts to find a cure, promote access to treatment and care and develop vaccines;

xi. Promoting human rights of people infected and affected with HIV/AIDS;

xii. Promoting positive living among people living with HIV/AIDS;

xiii. Advising the government on all matters relating to HIV/AIDS Control in the Country.

2.3 Legal Mechanism and Legislative Action

Existing literature argues that the critical AIDS situation is also a result of conspiracy of shame and silence, politicians have not escaped this conspiracy. Many remained unwilling to talk about AIDS even when it was killing members of their own families.

In Tanzania, parliament has done a lot in fighting this deadly disease. Parliament recently fulfilled its legislative duty by passing a bill for the enactment of the Tanzania AIDS Commission Act 2001. The Act provides inter alia for the establishment of the Commission (TACAIDS) and empowers it with various authorities in relation to fighting HIV/AIDS.

However, little has been done with regard to the enactment of laws, which are to be enforced to prevent the spread of HIV/AIDS. The Penal Code, a piece of legislation which solely deals with criminal matters, does not uphold sections for criminal offences and penalties against those who deliberately infect others.

Existing inheritance laws, which provide for a family member to inherit the widow of the deceased, are another factor in the spread of HIV infections where the deceased died of AIDS. Therefore, these laws should be reviewed and harmonised and more efforts should be made to influence customary laws and practices to become gender sensitive:

- Power relations in traditional and customary practices that inhibit equal participation of men and women in preventing the spread of HIV/AIDS should be addressed by all sectors;
- Extra marital relationships are tolerated for men, polygamy is legalised. Raped women tend to be blamed. Laws on minimum age for marriage of girls are not adequately enforced.

Parliament is also facilitating the effort in fighting HIV/AIDS by passing the budget estimates of the Ministry of Health and other organs, which wage the war against the epidemic.

For the first time, in the 2001/2002 financial year, each ministry and council was allocated funds for HIV/AIDS control activities. The over-all aim is to mainstream HIV/AIDS interventions in development activities of the sectors

at all levels. However, funding for HIV/AIDS activities has been in adequate and irregular. Most of the activities were externally funded either through NACP or directly to implementing NGOs and faith groups. As yet, there are no mechanisms for co-ordinating and harmonising external funding and it is difficult to quantify actual expenditures on HIV/AIDS. Currently, there is an international initiative to mobilise resources for HIV/AIDS.

At the national level, HIV/AIDS features high in the Medium Term Expenditure Framework (MTEF). There are indications for increased financial commitment from development partners to support HIV/AIDS interventions. There is growing interest from the private sector in HIV/AIDS. In the 2001/2002 fiscal year T.Shs 7.2 Billion (about US$ 8 million) was allocated to HIV/AIDS. This excludes funds allocated by councils.

SECTORS AND REGIONAL/COUNCILS BUDGET ESTIMATES

YEAR	SECTORS	REGIONS/COUNCILS	TOTAL
2000/2001	22,463,096,842	1,233,284,552	23,696,341,394
2001/2002	24,709,362,528	1,356,613,007	26,065,975,535
2002/2003	27,180,298,779	1,492,274,308	28,672,573,087

SOURCE MoH/NAPC, 2000

Tanzanian parliamentarians established a group known as “The Tanzanian Parliamentarians AIDS Coalition” (TAPAC) in April 2001. The formation of this organisation makes the commitment of a core group of Tanzanian parliamentarians to mobilise their fellow parliamentarians and constituents to address the HIV/AIDS epidemic. TAPAC’s activities are focused on mobilising parliamentarians to effectively carry out their roles at the national and local level in support of HIV/AIDS programs. TAPAC represents the first effort of its kind in Tanzania where a group of policy and decision-makers have come together to address the problems associated with AIDS. Members of parliament are in positions to affect how the national effort to battle the epidemic is directed as well fostering increased actions at the local council level.

This complements the massive efforts towards local government and health sector reforms and increasing roles and responsibilities of local authorities/councils, the public sector and civil society partnerships.

3. NATIONAL ADVOCACY STRATEGIES

As per the National Policy for HIV/AIDS/STDs under the Ministry of Health of 1995, strategies for AIDS control and prevention have components focusing on the following areas:

3.1 Education / Information

Promote awareness in the community about HIV/AIDS/STDs to a level where:

i. All are familiar, as a responsibility and duty, with the facts about HIV transmission;

ii. Individuals are able to assess their own risk and make decisions which protect them from transmission and about testing and counselling;

iii. Protective behaviour is sustained in the long run;

iv. It is appreciated and accepted that HIV infected persons do not pose a risk in every day situations;

v. Myths, prejudices and unnecessary fears are reduced to insignificant levels.

3.2 Prevention

To eliminate transmission through the use of preventive measures such as safer sex and drug-using practices, testing with counselling, removal of legal impediments and education to prevent the infection of people who care for infected individuals.

Promote and establish appropriate and up-to-date guidelines, rules, regulations and laws where none exist to safeguard individuals and the community against the risk of exposure to HIV/AIDS/STDs infection.

3.3 Treatment, Care and Counselling

To provide care for infected persons with appropriate and adequate treatment and services; physical, emotional, spiritual and psychological support, whenever possible within the existing health care system and through home-based care.

3.4 Access to and Participation in Social Services

To maintain quality of life for infected persons by preventing discrimination in relation to access to employment, financial support, housing, treatment, education and other social services.

3.5 Research

i. To support a research program consistent with the overall goal of the national strategic plan;

ii. To participate in HIV/AIDS research nationally and internationally and to establish a system to disseminate scientific information resulting from this research while upholding ethics that govern interventions in HIV/AIDS;

iii. Government will closely follow and collaborate in HIV vaccine development.

3.6 Sectoral Roles and Financing

i. To strengthen the role of all the sectors - public, private, NGOs, faith groups, PLHAs, CBOs and other specific groups - to ensure that all stakeholders are actively involved in HIV/AIDS work and committed to a framework for co-ordination and collaboration;

ii. To ensure strong and sustained political and government commitment, leadership and accountability at all levels;

iii. To establish a framework for co-ordinating fund raising activities, budgeting and mobilisation of human and material resources for activities in HIV/AIDS throughout Tanzania;

iv. To influence sectoral policies to address HIV/AIDS;

v. To encourage and promote the spirit of community participation in HIV/AIDS activities. This includes community representation at national and district level for fund raising, strategic planning and implementation by all sectors. It also includes ward and village level strategic planning for the prevention of transmission of HIV/AIDS and STDs, as well as care and support of PLHs, their dependants, families and orphans.

3.7 Legislation and Legal Issues

To create a legal framework by enacting a law on HIV/AIDS with a view to establishing multi-sectoral response to HIV/AIDS, to address legal and ethical issues in HIV/AIDS and to revise the legal situation of families affected by HIV/AIDS in order to give them access to family property after the death of a spouse or parent(s).

3.8 Other Strategies

i. To monitor the efforts towards community mobilisation for living positively with HIV/AIDS in order to cope with the impact of the epidemic while safe-guarding the rights of those infected or affected directly by HIV/AIDS in the community;

ii. Right abuses in HIV/AIDS and protect PLHAS and every one else in society against all forms of discrimination and social injustice;

iii. To provide appropriate effective treatment for opportunistic infections at all levels of the health care system;

iv. To work closely with the Ministry of Health Affairs, NGOs and faith groups in the fight against substance abuse;

v. To identify human abuse that increases the risk of HIV transmission;

vi. To prohibit misleading advertisements of drugs and other products for HIV/AIDS prevention, treatment and care.

4. ACTION PLAN

The Mid Term Plan ends in June 2002. This provides the opportunity to critically review the ongoing activities and scale-up effective interventions. It is particularly important to refocus the approaches so that the activities are more feasible and effective in controlling the epidemic. Among others, these activities are expected to:

i. Provide general guidelines for planning and budgeting HIV/AIDS control activities for the financial year 2002/2003 in the context of the MTEF;

ii. Facilitate compliance with and attainment of the national targets contained in the Abuja Declaration and United Nations Women Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment;

iii. Provide the framework for the HIV/AIDS component in developing a proposal for the Global Fund for supporting HIV/AIDS/TB/Malaria interventions that are constant with overall multi-sectoral strategy on HIV/AIDS.

In doing so the following activities are to be conducted:

4.1 Review and Scale-up On-going Activities in the Prevention of New Infections

This includes:

i. Ensuring safe blood transfusions and universal precautions to avoid transmission in health care settings;

ii. Expanding and strengthening management of STIs throughout the country;

iii. Strengthening interventions among the youth, both in and out of school;

iv. More aggressive condom promotion and access;

v. Promoting and expanding VCT and PMTCT facilities;

vi. Strengthening advocacy and initiating a national campaign;

vii. Developing effective and targeted communication strategies;

viii. Strengthening place interventions and mainstreaming HIV/AIDS activities;

ix. Conducting HIV/AIDS needs assessment for the disabled;

x. Consolidating and expanding district response initiatives and scaling-up current successful community based interventions;

xi. Promoting studies on social and cultural determinants of HIV transmission, gender and behaviour change;

xii. Reviewing HIV/AIDS control plans for sectors in the military alliance;

xiii. Maintaining dialogue with religious leaders.

4.2 Care and Support for PLHA

i. Strengthen efforts to promote an environment of openness and reduce stigma and discrimination of those infected and affected by HIV;

ii. Develop plans for strengthening the health care system to provide better health care services in general, including treatment for opportunistic infections, VCT/PMTCT, and access to antiretroviral therapy (ART);

iii. Initiate practical approaches for home-based care;

iv. Evaluate the efficacy of home remedies that have potential for the treatment of opportunistic infections;

v. Expand training of counsellors at all levels.

4.3 Impact Mitigation

This includes:

i. Conducting needs assessment for the management of orphans;
ii. Study the impact of HIV/AIDS in all aspects and at all levels.

4.4 Strengthen Programme Management

Capacity building in programme management, co-ordination, monitoring and evaluation:

i. Develop and disseminate simplified user-friendly HIV/AIDS policy guidelines;
ii. Print and distribute national policy on HIV/AIDS;
iii. Print, translate and distribute TACAIDS establishment Act;
iv. Conduct studies to establish benchmarks;
v. Recruit TACAIDS secretariat;
vi. Acquire, renovate and furnish office accommodation;
vii. Conduct situation analysis of accommodation;
viii. Develop mechanisms for effective monitoring and evaluation;
ix. Review and harmonise HIV/AIDS plans of action in key ministries;
x. Identify capacity building needs for TACAIDS and sector districts;
xi. Develop a management information system;
xii. Develop financial management systems and manuals for programme management;
xiii. Develop advocacy and communication strategies;
xiv. Finalise the national multi-sectoral strategy on HIV/AIDS;
xv. Expand HIV/AIDS/STDS surveillance.

4.5 Consolidate and Expand District Response Initiative and Scale-Up Successful Community-Based Interventions.

i. Harmonise mechanisms for co-ordination and financial management at district level;
ii. Facilitate adoption of planning and co-ordination mechanisms of district councils for all actors and partners;
iii. Conduct seminars for majors and municipal leaders to facilitate co-ordination and linkages between HIV/AIDS DRI and local government reform;

iv. Print and distribute supplementary school AIDS education booklets;

v. Provide training for teachers on the use of the booklets and distribute booklets to schools;

vi. Conduct a national campaign to complement DRI and AIDS education in schools.

5. ACHIEVEMENTS

5.1 Strengths, Weaknesses,Threats and Expected Output.

i. Strengths

- Strong political commitment and leadership;
- Tanzania Commission for AIDS is formally instituted to spearhead and co-ordinate the fight against the epidemic;
- The National Policy on HIV/AIDS in place;
- Strong international support, including DACC, UN, IPAA, TMAP;
- Involvement of the media and business sector in the national response;
- Wide acceptance of the campaign by Tanzanians;
- Well-established government administrative and communication structure from national to community levels.

ii. Weaknesses

- Slow speed of the formation of the Commission;
- Lack of clear mechanisms for multi-sectoral co-ordination and financial management;
- Inadequate counselling capacity at all levels;
- Inadequate VCT/PMTCT services;
- Inadequately equipped health care system for management of HIV/AIDS/STIs.

iii. Threats

- Low level of awareness of the speed of the spread of HIV in the community;
- Stigma and negative information regarding HIV/AIDS.

iv. Expected Output

It is envisaged that during this period:

- All sectors and implementing agencies will have plans and a budget for scaling-up on-going and new HIV/AIDS interventions in the 2002/2003 financial year;
- Councils will have co-ordinated and comprehensive multi-sectoral plans in the respective areas;
- There will be increased funding for HIV/AIDS activities in all sectors from internal sources;
- The National Multi-Sectoral Strategy on HIV/AIDS will be finalised;
- TAC/AIDS shall be fully functional.

6. CONCLUSION

AIDS IS AN EXPENSIVE DISEASE.The medicines are costly and patients are unable to work, but still need food.Many people in African countries with AIDS never get to hospital or AIDS clinics simply because they are too poor or too weak to travel.

In 1997, Nelson Mandela (former South African president) warned the Economic Forum in Davos that "AIDS kills those on whom society relies to grow the crops, work in the mines and the factories, run the schools and govern nations and countries".

Today in many African countries AIDS has already wiped out major gains in development registered over the past decade. But Africa's AIDS disaster is only beginning. Millions are infected but have not yet started falling ill and new infections, according to existing literature, are occurring at the rate of around 4 million a year.

To quote Callisto Madaro, Vice President of the World Bank's Africa Region, at a recent AIDS Conference in Lusaka, Zambia; "HIV is now the single greatest threat to future economic development in Africa … *AIDS is not only taking Africa's present, it is taking away Africa's future."*

Hence it is the time to fight shoulder to shoulder against this disease. Let us discuss and be open on this issue. This should start from the family level up to national level and therefore extend to SADC-PF and regional level.

The former UN Security General, Boutros Boutros Ghali, said, "HIV/AIDS will not be controlled unless all of us, acting as a global community unite our efforts, co-ordinate our actions and reduce duplications" (World Health

Forum: 1995). Information and education are still the last weapons to be used to combat this disease, of course serious commitment and policy formation in SADC-PF countries are a must in dealing with the deadly disease.

We must adhere to the principles of co-operation, social cohesion, solidarity among SADC-PF countries, other African countries and the world in general in combating the disease.

REFERENCES

1. The African, 05.04.2001.
2. Majira, 07.04.2001.
3. Word Health Forum, "An International Journal of Health and Development", Geneva, Vol. 16, No.4,1995.
4. Word Bank Institute "Development Outreach" Washington, Vol. 1, No.2, 1999.
5. V. Chandra. All against AIDS, The Cooper Bett Health Education Project, Zambia Aid, London, 1992.
6. World Health Organisation Press release WHO/9/12, February 1992
7. Chin, J & F. Sonnenberg. The Epidemiology and Projected Mortality of AIDS in the United Republic of Tanzania, Background Paper presented for Tanzania AIDS Assessment and Planning Study Revised Draft, 1991.
8. Beijing Review Vol.43, No.24, June 2000.
9. Ministry of Health, Tanzania National AIDS Control Programme HIV/AIDS/STDs, Surveillance Reports Epidemic Unit, Dar Es Salaam, 1991, 1996, 2000.
10. Prime Minister's Office. National Policy on HIV/AIDS, Dodoma.2001.
11. Tanzania Commission for HIV/AIDS (TACAIDS). Intensifying the fight against HIV/AIDS in Tanzania, Dar Es Salaam, 2001.
12. The Tanzania Commission for AIDS Act, 2001

CASE STUDY:

The National HIV/AIDS Policy of Zambia

INTRODUCTION

Since the first diagnosed case of AIDS in Zambia in 1984, HIV/AIDS has become increasingly widespread with an estimated adult HIV prevalence of 14% in rural areas and 28% in urban areas in the 15 to 49 year old age group. Although the epidemic is showing signs of stabilisation in urban areas, the rates continue to rise in some rural areas.

About one third of the world's population is infected with tuberculosis (TB). In 1995 there were 9 million cases of TB with 3 million deaths. 95% of TB cases and 98% of TB deaths occur in developing countries. Furthermore, 75% of TB cases are in the economically productive age group.

The impact of HIV/AIDS/STI/TB has been felt by all sectors of society. In recognition of the worsening HIV/AIDS/STI/TB situation and the need to mobilise other sectors to actively participate in the fight against the epidemic, a multi-sectoral approach has been adopted.Realising that many problems arising from the epidemic have socio-economic and developmental ramifications, measures contained in this policy are aimed at mitigating the root causes and consequences.

A multidimensional approach has, therefore, been adopted in dealing with the epidemic and its impact. For this to succeed it is important that a partnership approach at international, regional, national, community, and individual levels is harnessed. This partnership requires effective co-ordination of the policy and strategies.

This policy, therefore, provides a framework for addressing the HIV/AIDS/STI/TB situation in Zambia, outlining the causes and factors that perpetuate the transmission and the impact of HIV/AIDS/STI/TB on the Zambian population. This document also outlines the response and impact mitigation interventions already in place, while also stating the vision, objectives, policy measures, institutional legal framework and roles to be performed by Government and other stakeholders.

1. SITUATION ANALYSIS

1.1. Global Context

1.1.1. HIV and AIDS have, for the past two decades, continued to spread across all continents killing millions of adults in their prime, disrupting and impoverishing families, turning millions of children into orphans, weakening the workforce thereby threatening the social and economic fabric of communities as well as political stability of nations.

1.1.2. WHO-UNAIDS report showed that by December 2000, 36.1 million men, women and children around the world were living with HIV/AIDS. This included 34.7 million adults, of whom 16.4 million were women, and 1.4 million children. 21.8 million had died from the disease, that is 7.5 million men, 9 million women and 4.3 million children.

1.1.3. Of Sub-Saharan Africa's 25.3 million people living with HIV/AIDS, 16.4 million have died.The biggest tragedy is the growing number of orphans estimated at 13.2 million worldwide of which 12.1 million are in Africa.

1.1.4. The arrival of HIV/AIDS/STI/TB has caused a re-emergence of TB epidemics throughout Southern Africa. As many as two-thirds of TB patients may be HIV positive. HIV infection weakens the immune system of otherwise healthy adults. Many, perhaps half, of all adults in southern Africa carry a latent TB infection, which is suppressed by a healthy immune system.When HIV weakens the immune system, it can no longer control the TB infection and overt TB can develop.

1.2. National Context

1.2.1. The population of Zambia now stands at 10.2 million people with an annual growth rate of 2.9% (Census-2000). More than 50% of the population is less than twenty years of age and constitutes the most vulnerable group to HIV.

1.2.2. Currently 20% of the adult population aged 15 to 49 are living with HIV. By June 2000 there were 830,000 people over the age of 15 years reported to be living with AIDS. Of these, 450,000 were women while 380,000 were men. The peak ages for HIV among females is 20 to 29 years while that for males is 30 to 39 years. Young women aged 15 to 19 are five times more likely to be infected compared to males in the same age group. It is estimated that 25% of pregnant

women are HIV positive. Approximately 39.5% of babies born to HIV positive mothers are infected with the virus.

1.2.3. The average TB case rate between 1964 and 1984 remained constant at 100 per 100,000 population. Since the advent of the HIV/AIDS epidemic, the TB case rate increased nearly five-fold to over 500 per 100,000 population in 1996.

1.2.4. The TB co-epidemic is one of the most serious public health problems that have been triggered by the HIV/AIDS epidemic.There are now in excess of 40,000 new TB cases reported every year. This figure is expected to rise by 10% annually in the next few years. TB co-infection has also resulted in an increased mortality rate of TB patients on treatment by over 15%.

1.2.5. Sexually transmitted diseases (STDs) constitute one of the major public health problems in Zambia. They account for 10% of all documented outpatient attendance in public health facilities. The common STDs include gonorrhea, syphilis, chancroid, trichomoniasis and herpes genitalis. More than 50% of persons with a history of STD are infected with HIV.

1.2.6. The probability of transmitting HIV during unprotected sex rises dramatically if either partner is infected with another sexually transmitted disease (STD), such as syphilis or gonorrhoea. These infections form ulcers and sores that facilitate the transfer of the virus. A recent study in Ndola, for example, indicated that 11.3% of men and 14.0% of women were infected with syphilis. Two out of every three sex workers in the Ndola commercial sex worker study were infected with an STD.

1.2.7. There are, however, some hopeful indications. The prevalence of HIV positive tests in 15 to 19 year-old youths dropped over most of the country between 1994 and 1998. In Lusaka, for example, while the rate was 28% in 1993, it had dropped to 15%, in 1998. At the same time, the overall prevalence of positive tests in the whole population appears to be stable and is not increasing. This has been attributed to behaviour changes. The recent Sexual Behaviour Survey has documented further evidence of behaviour changes. Although the current burden of infection will continue to impact Zambia for many years, it is hopeful that the tide may be turning.

1.3. The Transmission of HIV

1.3.1. HIV infection is transmitted primarily through heterosexual contact and perinatal (mother-to-child) transmission during pregnancy, at birth and while breastfeeding. Other modes of transmission include contaminated blood, re-use of needles, and men having sex with men.

1.3.2. Heterosexual transmission of HIV in Zambia is increased by:

- the high prevalence of sexually transmitted infections;
- poor socio-economic status;
- the practice of dry sex;
- unprotected sex with multiple partners;
- multiple sexual partners;
- sexual activities at an early age.

1.4. Factors that Perpetuate the Transmission of HIV

1.4.1. *Socio-cultural beliefs and practices*

The social cultural beliefs, which subordinate women in society, make them more vulnerable to HIV infection. For example, a woman is taught never to refuse sex with her husband even when he is known to be involved in extra marital liaisons, or is suspected to have HIV or indeed any other STI.

Difficult socio-economic conditions compel women to exchange sex for money or gifts. Other cultural practices such as dry sex and the traditional practice of widow/widower cleansing also facilitate the transmission of HIV.

1.4.2. *Mobility of groups more vulnerable to HIV*

Includes displaced populations such as long distance truckers, migrant workers, cross-border trading, fishing and fish traders.

- Uniformed Personnel: Although there is been no study on HIV prevalence among uniformed personnel due to their tour of duties, this group is considered vulnerable to STD and HIV infection, partially as a result of their high mobility, which keeps them away from their spouses and partners for extended periods of time. Active programmes to prevent HIV are being implemented for this target group. A Ministry of Defence HIV/AIDS/STI/TB programme has been set up which provides the following services: health education; condoms; screening and treatment of sexually

transmitted diseases; counselling; home-based care; orphan and widow/widower support. The programme is working well but requires further strengthening.

- Prisoners: There are approximately 13,000 men and women in Zambia's prisons. Their vulnerability to HIV stems from unprotected sex (frequently in the form of rape), high prevalence of STD, and very low and inconsistent use of condoms. The law currently prohibits condom distribution in prisons. Unprotected penetrative anal intercourse is common. In some instances, prisoners delay accessing medical services, thus delaying the timely diagnosis and treatment of STDs.

1.4.3. *Poverty*

There is a synergetic relationship between poverty and HIV/AIDS. HIV can bring poverty and promote HIV/AIDS. More than 70% of the population falls below the poverty level and of these 90% are women. This is in addition to an increasing proportion of female-headed households, mainly due to the HIV/AIDS epidemic.

The high poverty levels limit the enjoyment of social and economic rights such as education, health care, employment and social services.

1.4.4. Inadequate information and education on HIV/AIDS/STI/TB, reproductive health, and life skills

1.4.5. Discrimination and stigma

1.4.6. *Gender Perspective*

Women have limited access to productive resources such as land, credit, skills, capital, technology and information. As a result, most women are economically dependent on men, which contributes to their inability to negotiate for safer sex and also engage in commercial sex in order to survive. Girls from poor families are sometimes forced into early marriages, sexual arrangements in exchange for money or school requisites and thus become vulnerable to HIV.

1.5. Factors that perpetuate transmission of TB and STDs

TB	**STDs**
o HIV-infection	o Poverty
o Overcrowding	o HIV-infection

o Poor ventilation	o Unprotected sex
o Poor nutrition	o Multiple sexual partners
o Incompliance to treatment	o Incompliance to treatment

1.6 Impact of HIV/AIDS/STI/TB

1.6.1. *Household and community level*

At the family level the majority of those who are dying of HIV/AIDS are in the most productive years and very often the sole breadwinners in the household. HIV/AIDS has therefore had a devastating effect through the loss of income, thus leading to poverty, changes in patterns of household expenditure, limited access to health services and other social services and the weakening of the family as the basic social unit, particularly the extended family, which is an important social safety net.

1.6.2. *Orphans and Vulnerable Children*

About 700,000 children have lost one or both parents due to HIV/AIDS. The majority of these orphans have to live with extended family members or neighbours with about 6% becoming street children and less than 1% living in orphanages. Many orphans do not attend school or are forced to drop out of school. In most cases, grandparents are left to care for the young and this is usually in a situation where these grandparents have little or no source of income. A new phenomenon of child-headed households has emerged.The impact of orphans placed a tremendous strain on the extended family and the social system to provide the orphans with the needed care, resources and social guidance.

1.6.3. *People With AIDS (PWA)*

The adverse consequences include stigmatization and discrimination. It is also common for people with HIV to lose their income as their health deteriorates and they are unable to work regularly. Sometimes, people with HIV are abandoned by their families and forced to live in destitution.

1.6.4. *Social economic impact*

The HIV/AIDS epidemic has negatively impacted on the social and economic spheres and has contributed to the reversal of many of the development indicators that were achieved before the advent of the

epidemic. Infant and child mortality rates, after decades of steady improvements, are now worsening. Tuberculosis, which had been contained, is now one of the most serious public health problems.

In part, what makes the HIV/AIDS epidemic so serious is that it has a pervasive impact on virtually all aspects of development and society in Zambia: Health, education, economy, the labour force, agriculture and transport. Children, women and families feel the impact.

1.6.5. *Work place impact*

HIV/AIDS has negatively impacted on agriculture, the public service and the private sector in a variety of ways, inter-alia by absenteeism, loss of productive workers, huge funeral costs which have generally led to diminished productivity and ultimately affected our human resource base thereby undermining our efforts at revitalising the economy.

i. Businesses in Zambia have reported an increase in mortality and morbidity among their workforce due to HIV/AIDS. This has affected productivity, recruitment, and, in particular, loss of trained personnel. Industries have reported an increase in funeral disbursements and ex-gratis payments.
   As the epidemic persists, the private sector will be adversely affected in a number of ways. The workforce will not decline but will change in structure by becoming younger, inexperienced and less well trained. A disproportionately high number of skilled personnel will be lost, contributing to reduced productivity. Stigmatisation and discrimination, targeted at people who are HIV positive, in the workplace will compromise morale and work performance.

ii. Impact of HIV/AIDS on Education: There is a high mortality rate among teachers, which has led to a shortfall. The productivity of teachers has dropped in part as a result of absences due to frequent illnesses, which has in turn affected the quality of education.

   In 1998, the Ministry of Education reported that 1,331 teachers died as result of AIDS. Furthermore, studies have reported an HIV prevalence rate of up to 40% among teachers. Given the

prevailing high rate of mortality and morbidity, the scarcity of human resources is further aggravated. According to a recent study, even if teachers' training colleges increased their production of teachers, the shortfall of teachers attributed to deaths from AIDS will not be met in the short to medium term. This projection does not even take into account expansions that are required under a universal education scheme. As provinces are obliged to contribute to the funeral costs of teachers and civil servants in general, expenses for coffins and funerals have increased quite dramatically.

Apart from being understaffed, the productivity of teachers has dropped, in part as a result of absences due to illness. Another related factor is an increase in the average time taken off work to attend funerals. Even when teachers are present in class, a study has shown that they suffer from exceedingly high levels of stress attributed to trying to tackle the immense and complex social situations more and more students are faced with due to AIDS deaths in the family.

iii. Health: In terms of the impact of HIV/AIDS on the health sector, this continues to be a great concern given the consequent astronomical cost involved in care and treatment. The treatment of opportunistic STD infections in HIV infected persons is expensive and has placed an unprecedented burden on the delivery of comprehensive health care. The services available cannot meet the demand and Government has been unable to invest adequately in this sector due to inadequate national resources.

Another aspect of the impact on the health sector has been the high morbidity and mortality among health workers, thereby affecting the quality of health care offered.

1.7. Gender Perspective

Although women constitute about half of Zambia's population, they are disproportionately infected by the HIV. For a long time HIV/AIDS researchers and analysts believed that over the course of an epidemic, about equal numbers of men and women would become infected. The multi-centre study confirms this pattern. The study

revealed prevalence rates of 32% among females and 25% among males in Ndola.

This unbalanced sex ratio may occur in part because women are more prone to infection than men. Research indicates that women are two to four times more vulnerable to HIV infection than men during unprotected intercourse because of the larger surface area exposed to contact. Similarly, women are more vulnerable to other sexually transmitted diseases, the presence of which greatly enhances the risk of HIV infection. Some STDs, presenting recognisable symptoms in men, are often asymptomatic in women and therefore remain untreated.The 1996 Demographic and Health Survey (DHS) indicates that men are twice as likely as women to seek treatment for STDs. Whatever the exact dynamics, young women attain higher HIV infection levels at notably younger ages than young men. Women lack control over their lives and are taught from early childhood to be obedient and submissive to males, particularly males who command power such as a father, uncle, husband, elder brother or guardian. In sexual relations, a woman is expected to please her male partner, even at the expense of her own pleasure and well-being. Dominance of male interests and lack of self-assertiveness on the part of women puts them at risk.

Women are taught to never refuse having sex with their husbands, regardless of the number of partners he may have or his unwillingness to use condoms, even if he is suspected of having HIV or another STD. A number of women continue to practice dry sex, which increases vulnerability to infection through bruising and laceration of genital organs of both partners.

1.8. Efforts in Addressing the HIV/AIDS Epidemic

Plans and Programmes

1.8.1. The following plans were put in place as a response to the epidemic:

a) In 1986, government established the National AIDS Prevention and Control Programme.

b) In 1987 an emergency short-term plan was developed to ensure safe blood and blood product supplies.

c) 1988 - 1992 First Medium Term Plan which prioritised eight operational areas: TB and Leprosy; information, education and

communication; counselling; laboratory support; epidemiology and research; STD and clinical care; programme management; and home-based care.

d) 1994 - 1998 Second Medium Term Plan which was multi-sectoral in design and incorporated a mechanism for inter-sectoral co-ordination and collaboration.

e) 2001-2002 Development of National Strategic Framework.

The above-mentioned plans attempted to incorporate a mechanism for inter-sectoral co-ordination and collaboration and contained interventions on prevention, treatment, care and support.

Multi-sectoral Co-ordination and Collaboration

1.8.2. It has been acknowledged that the initial responses to HIV/AIDS were inadequate to contain a problem that was more than just medical in nature. The subsequent integrated programmes have sought to foster political commitment at the highest level, develop inter-sectoral approaches, encompassing all government ministries, the private sector and civil society, fully involve people with AIDS and develop effective AIDS impact mitigation strategies.

The desire to strengthen the multi-sectoral approach in the fight needs encouragement.

Below are the activities that will require the participation of various players.

1.8.3. Prevention and control

Prevention has been the cornerstone to the national response through co-ordinated efforts of government and civil society. The major interventions have been raising awareness and influencing behaviour change, voluntary counselling and testing, prevention of mother-to-child transmission, promotion of condom use; case finding and treatment of STDs and provision of safe blood and blood products.

a) Information, Education, Communication (IEC) and Life Skills Programmes

The main thrust of the IEC programmes was the use of mass media to inform the general public about HIV/AIDS/STI/TB. The channels used included television, radio, billboards and

pamphlets. IEC also included the introduction of applicable materials in school curricula. Several NGOs and churches have implemented IEC activities in their respective programmes.

Government, through the Ministry of Education, has adopted a number of HIV/AIDS/STI/TB and reproductive health teaching materials in the mainstream school curriculum at national level. This is within the context of Life Skills education for boys and girls from primary school up to tertiary levels. Special life skills programmes were also developed by NGOs and targeted special groups such as commercial sex workers, truck drivers, out of school youths, military etc.

These programmes tend to cover smaller populations along the line of rail. In general, the development of IEC materials does not involve the beneficiaries, as a result beneficiaries do not take ownership. Sometimes the messages are not well targeted, culturally acceptable or in compliance with the law.

b) *Condom access, distribution and use including other barrier methods*

Although the knowledge of condoms is high, use is low (24%, ZSBS 1998). Social marketing has to date been the primary strategy for increasing the access, acceptability and use of condoms in Zambia. Male condoms were actively marketed through mass media promotions. Traditional outlets such as health centres, pharmacies and drug stores have been used. Non-traditional outlets have also been targeted for condom sales and these include bars and provision stores. A female condom was introduced, but its use is very low.

Condoms are easily accessible in the urban setting compared to the rural areas.

The barrier methods such as spermicides are being promoted through family planning, but their use is low.

c) *Blood Transfusions*

Government established the blood transfusion service with centres at provincial headquarters. National guidelines for blood transfusions were developed and are in use. All district, provincial and central referral hospitals have blood transfusion

facilities. Blood products that are used in these health institutions are screened for HIV and syphilis, and to a lesser extent for Hepatitis B. Prospective donors are screened without exception through the use of a risk assessment tool and any indication of heightened risk is sufficient to disqualify the donor. There are frequent shortages of test kits for HIV, syphilis and Hepatitis B and there are no mechanisms for the beneficiaries to know the safety of the blood they are getting.

d) *Treatment of Sexually Transmitted Infections (STIs)*

The National STD Control Programme of Zambia was launched in 1980. Its main responsibilities were to reduce the transmission of STD, to provide efficient diagnostic and treatment services and to conduct research on STD.

A network of 62 STD clinics located at central, provincial and district hospitals were established to ensure aetiological management. From 1990 to 1994 diagnostic clinical management and prevention services at these health centres were improved through training and the provision of diagnostic equipment and supplies. Since 1994, there has not been effective support to the programme in all the areas mentioned.

Currently, many health centres in Zambia are adopting the use of the syndromic approach for STD management, especially as they lack equipment and trained laboratory staff. Guidelines were distributed and health worker training has commenced in some districts. In five urban districts, syndromic management was integrated into a maternal and child health services package at health centre level to improve pregnancy outcomes. The challenges are staff training, drug availability and public awareness and integration into MCH and family planning.

e) Prevention of Mother-to-Child Transmission for STI and HIV

Prevention of mother-to-child transmission of STI was part of the STD programme. Of late, the programme has not been successful due to shortages of testing kits for the maternal syphilis screening programme and drugs for ophthalmia neonatorum prophylaxis.

Prevention of mother-to-child transmission has taken the front role in preventing vertical transmission. Currently this is piloted in 4 sites and is yet to be up-scaled.

f) *Voluntary Counselling and Testing (VCT)*

Voluntary Counselling and Testing (VCT) is the entry point for diagnosis and management of infected persons. It has now become part of a wide range of interventions such as prevention of mother-to-child transmission of HIV, TB programmes, STD programmes, treatment and home-based care. VCT also helps challenge denial of infection and helps members of society to recognise and accept that one can live with HIV infection and show no outward signs and symptoms.

Government, through the National AIDS Programme, has trained counsellors throughout Zambia, though this has not adequately satisfied the need. The vision is to decentralise counselling and testing facilities and make them readily available in public and private institutions within the communities. The service, both institution- and community-based, is currently limited to major centres.

g) *Vaccine Development*

It is clear that a safe, effective and affordable HIV vaccine would offer the best hope and important tool for the future control of the HIV epidemic. Government through the National HIV/AIDS/ STI/TB Council has classified vaccine development as a priority. However, the implementation of the HIV vaccine strategy in the country, the issue of personnel training, laboratory facilities infrastructure- and institutional arrangements for scientific and ethical appraisals for vaccine trials need to be addressed.

1.8.4. Treatment, Care and Support

The approach has been to provide support through counselling and testing, treating the symptomatic HIV infected patients and encouraging home-based care through community approaches.

a) *Treatment of HIV/AIDS/STI/TB*

Treatment has mainly been confined to treating symptomatic HIV infected patients with opportunistic infections, TB and STIs.

These services have been provided within the normal health and traditional care delivery systems. These drugs are not readily available.

Since the 1990s treatment has included antiretrovirals (ARVs), mainly in the private sector and to some extent in public institutions where patients procured their own medicine or where treatments is initiated outside and follow-up is done in Zambia. Although the private sector has provided these services, it has limited access to laboratory facilities for monitoring patients. In addition some drugs are brought in without proper registration, evaluation, and quality control.

Government recognises that ARVs prolong and improve the quality of life and that those who have access to these drugs continue to lead a normal life and contribute to national development. However, the ARVs are now in the country and only dispensed through the private sector, leading to most Zambians living with HIV/AIDS having no access to ARVs because of cost implications. Also there are no official operational guidelines on the clinical application of various combinations of ARV drugs.

For Government to implement ARVs in the public sector, the issue of cost pertaining to personnel training, drugs, laboratory facilities and physical infrastructure needs to be addressed.

b) *Traditional and alternative medicine/remedies*

It is recognised that most Zambians seek traditional and/or alternative remedies/treatment. Many claims to curing HIV/AIDS/STI/TB have been made by the alternative/traditional practitioners but these have not been evaluated in terms of efficacy, potency and toxicity. There is no collaboration between western and alternative medicine.

c) *Home-based Care*

The development of home-based care models in Zambia is partly in response to the unprecedented costs within the health sector and has many implications. Initiated to relieve the pressure on hospital beds, home-based care in Zambia is implemented in two ways:

i. Hospital initiated outreach programmes (vertical programmes) reaching out to the communities and slowly integrating into community activities;

ii. Community initiated programmes (horizontal programmes) often by church-based organisations and other voluntary organisations. These initiatives rely on community volunteers with the support from community-based organisations, religious and health facilities.

Although home-based care has been found to be an effective complement or alternative to hospital services, it has a cost implication and therefore places an economic burden on those providing care on voluntary basis. This limits the ability of the provider of home-based care to offer services on a wider scale. In addition, due to limited resources for outreach activities, hospital initiated community programs have not reached a wider community.

d) Support given to the Affected and Infected

i. General

Continuous counselling of the affected and infected exists but on a limited scale. There is a need to expand the services for wider coverage. Support appears to be limited and whatever help there, is comes from institutions such as the religious, Government Public Welfare Assistance Scheme, the Department of Social Welfare, small NGOs and other home-based care programmes.

Other programmes such as drop-in centres are involved in food provision, education and recreation but they are on very small scale and generally under-funded.

At the community level, small-scale agricultural schemes are being managed with profits going to those most in need as decided by the project committee.

Coping strategies at household and community level have mainly bordered on small-scale income generating activities. Village public assistance committees are functional in some areas and have undertaken projects for self-improvement. Community schools have been initiated. Despite the great

burden that has been placed on the community, it is evident that community commitment is extremely strong in Zambia.

ii. People With AIDS (PWA)

PWA have come together to form the Network of Zambian People Living with HIV/AIDS (NZP+). This NGO, with a current membership of over 1,000, aims to promote and enhance the quality of life, dignity and self-esteem of people with HIV/AIDS/STI/TB and to reduce vulnerability to HIV infection. NZP+ provides an important contribution to national discourse on HIV/AIDS. Also, NZP+ is actively involved at the community, district and national level in shaping the response to the epidemic. They accomplish this by participating in the design, development and implementation of HIV/AIDS-related policies and programmes. It is now customary for government ministries and agencies to include NZP+ members in deliberations related to HIV/AIDS and such partnership is advocated with other sectors in the country. There is need to strengthen and expand this effort.

iii. Orphans and vulnerable children

Individuals, Community Based Organisations (CBOs), NGOs and religious organisations are currently managing the response to orphaned children in Zambia. Government's institutional framework, based in the Department of Social Welfare in the Ministry of Community Development and Social Services (MCDSS), is involved in the provision of services to orphans as well as the provision of grants to child-friendly NGOs and CBOs. The challenges are the identification of orphans especially in rural areas, public awareness of available services and limited resources. There is need to standardise childcare provisions. Coping mechanisms for orphan care within communities are not well developed.

1.8.5. Human Rights and HIV/AIDS

Government has guaranteed the rights and freedoms of individuals through the Constitution. These rights include the right of access to health and other social services without discrimination and also apply to work place situations.

a) *Employment and the Workplace*

Section 28 of the Employment Act requires that a Medical Officer shall medically examine every employee before he/she enters into a contract of service of at least six months duration. The purpose of the examination is to ascertain the fitness of the employee to undertake the work, which he/she is required to do. Though the Act does not require that prospective employees be tested for HIV/AIDS some institutions do request mandatory testing. However, there is no law protecting employees against this.

b) *Confidentiality*

HIV/AIDS/STI/TB are notifiable diseases under the Public Health Act (Infectious Diseases Regulations). Confidentiality is currently upheld for all diseases and all clients' personal data should be kept in confidence. However, there is no specific regulation on sharing one's HIV/AIDS status.

c) *Stigma, Discrimination and Ethical issues*

People with HIV/AIDS, STD and TB are stigmatized and they experience some form of discrimination. This in part is due to beliefs that AIDS is associated with illicit sex and a result of sin. Some of the stigma is associated with misconceptions about how HIV is acquired.

The adverse consequences of such stigma include increased burden and suffering among those living with AIDS, a reluctance of individuals to know their HIV status, delay in seeking health care, and delays by communities to respond to HIV prevention.

Fair labour practices require that all employees, be treated equally without discrimination regardless of HIV status.

In collaboration with civil society and legal affairs institutions, attention is now being focused on the rights of vulnerable groups such as women and children, with the intent of mitigating the discriminatory aspects of HIV/AIDS/STI/TB. Much work remains to be done to address the society-imposed stigma associated with the condition.

Women and children remain vulnerable to losing their property and opportunities for legal recourse are in the developmental

stages. Of particular interest to NZP+ is the elimination of stigma associated with HIV/AIDS/STI/TB. NZP+ members have been models in this regard and are contributing to assist communities to be more open in their discourse on HIV/AIDS/STI/TB, build more tolerance and make their responses more people-centred.

1.8.6. Research and Development

Research is on-going in biomedical, social, traditional/alternate medicines and economic fields. There is no prioritisation, co-ordination, appropriate infrastructure, or trained human resource. There is need to have appropriate linkages to conduct HIV/AIDS related research.

1.8.7. Monitoring and Evaluation

A number of clinical, epidemiological, behavioural and impact studies related to HIV/AIDS have been conducted. Sentinel surveillance system for HIV and AIDS population based studies have been used to monitor the trend of the HIV epidemic. A system of collecting information from health facilities is in place to capture cases of AIDS, TB and other STDs. However, data from various programmes and ministries have not been collated and analysed at the national level.

1.9. Institutional Framework

An effective response to the HIV/AIDS epidemic requires a partnership approach, involving government ministries, local and international NGOs, CBOs, religious organisations, the private sector, UN agencies and bilateral donors.This partnership approach requires effective co-ordination of the policies and activities in each of these different sectors in order to ensure complimentarity in activities and avoid the inefficient use of limited financial and human resources.

A multi-sectoral and multi-dimensional institutional framework has been put in place comprising:

i. Cabinet Committee of Ministers, which currently includes Ministries of Health; Mines and Minerals Development; Education; Communications and Transport; Information and Broadcasting and Information Services and Finance and National Planning.The Committee's mandate is to provide policy direction, political leadership and advocacy. However, there is need to revisit this set up.

ii. The National HIV/AIDS/STI/TB Council established to co-ordinate, carry out monitoring, evaluation and research and providing technical guidance to implementing agencies. The Council has created:

   a) a forum for a common sectoral approach in the strategic planning for HIV/AIDS/STI/TB, and;

   b) co-ordinated priority setting for fighting the HIV/AIDS/STI/TB epidemic by all stakeholders with effective utilisation of resources.

iii. HIV/AIDS/STI/TB Focal Point Persons in Ministries, parastatals and other private institutions have been appointed to perform HIV/AIDS/STI/TB functions as a secondary role. These persons need to internalise the issue of HIV/AIDS so as to be effective. However, this role is taken as a secondary role.

iv. A number of NGOs are supplementing government efforts. However, there is no formal linkage between implementing agencies (NGOs) and the co-ordinating body (NAC).

The problem with institutional arrangements is that there is no multisectoral structure at Provincial and district level to co-ordinate the HIV/AIDS/STI/TB activities.

1.10. Legal Framework for National HIV/AIDS/STI/TB Council

1.10.1. Currently there is no national body that co-ordinates efforts made to fight HIV/AIDS by the private, civil society and government institutions. Therefore, there is a need to establish the National AIDS Council through an Act of Parliament.

1.10.2. There is a vacuum in the existing legislation with regard to the provision for proactive services and measures to fight HIV/AIDS. There is need to review and amend the existing legislation.

1.11. Political Commitment

Government has taken the right first step by establishing the Cabinet Committee of Ministers, the National AIDS Council and Secretariat. Sustained advocacy and political commitment has, however, been ad hoc and erratic especially at lower levels of the political hierarchy.

2.0. VISION, GUIDING PRINCIPLES AND OBJECTIVES

2.1. Vision

A nation free from HIV and AIDS.

2.2. Guiding Principles

2.2.1 The policy is guided by the following underlying principles that:

a) An appropriate legal framework is essential to the overall attainment to the vision.

b) An appropriate national co-ordination and advocacy framework is essential for the development, implementation and co-ordination of HIV/AIDS/STI/TB strategies and interventions;

c) HIV/AIDS/STI/TB is a serious public health, social and economic problem affecting the whole country to be addressed as a political, developmental and national security priority, requiring a multi-sectoral approach;

d) Information, education and communication for behaviour change is a cornerstone for the prevention and control of HIV/AIDS/STI/TB;

e) Providing treatment, care and support are essential to minimise the personal and socio-economic impact of HIV/AIDS/STI/TB;

f) Human rights and the dignity of all people, irrespective of their HIV status, should be respected and that stigma and discrimination against people with HIV/AIDS are eliminated;

g) Gender mainstreaming in HIV/AIDS issues is a central element in the fight against the epidemic;

h) A supportive social economic environment at all levels of society enhances the response to HIV/AIDS/STI/TB by individuals, families and communities.

2.3. Objectives

2.3.1. In order to achieve the vision, the following objectives will be pursued to:

a) Provide a legal framework for the establishment of a multi-sectoral autonomous institution for technical guidance to implementing agencies and monitor and evaluate the national response to HIV/AIDS/STI/TB;

b) Provide a framework and facilitate advocacy and social mobilisation in order to promote partnership in the fight against HIV/AIDS/STI/TB;

c) Intensify and strengthen preventive intervention programmes by various stakeholders in order to reduce the spread and impact of HIV/AIDS/STI/TB;

d) Reduce morbidity and mortality related to HIV/AIDS/STI/TB;

e) Eliminate the socio-economic impact of HIV/AIDS/STI/TB;

f) Uphold and protect the human rights and dignity of all people with HIV/AIDS/STI/TB;

g) Ensure gender mainstreaming in all HIV/AIDS/STI/TB interventions;

h) Encourage and support research in HIV/AIDS/STI/TB prevention and management;

i) Ensure mobilisation of resources by Government for the implementation of HIV/AIDS/STI/TB interventions; and

j) Monitor and evaluate interventions of the National HIV/AIDS/STI/TB Policy.

3.0. POLICY MEASURES

3.1. Domestication of international instruments and declarations on HIV/AIDS.

3.1.1. Government will:

a) Uphold the international declarations assented to on HIV/AIDS and translate them into strategies suitable to the local environment;

b) Collaborate with international and regional organisations with similar objectives and strategies in addressing HIV/AIDS/STD/TB.

3.2 Political Commitment

3.2.1. In order to provide overall national leadership in the response to-HIV/AIDS/STI/TB, Government shall:

a) Declare HIV/AIDS as a national disaster;

b) Require political leaders at all levels to mobilise and sensitise the nation on HIV/AIDS.

3.3. Multi-Sectoralism

3.3.1. In order to achieve the stated vision of a nation free from HIV/AIDS, Government shall adopt a multi-sectoral approach so as to:

a) Ensure that all ministries effectively streamline and enhance their HIV/AIDS, core activities;

b) Support religious organisations to adopt effective approaches that enable them to discuss, understand and provide appropriate HIV/AIDS preventive services, care and support to their respective constituencies;

c) Support traditional institutions to adopt effective approaches that enable them and the community to discuss, understand and provide appropriate HIV/AIDS preventive services, care and support within the context of their respective social values;

d) Involve and encourage employees, employers, trade unions and other workplace-related institutions to initiate and implement workplace-based HIV/AIDS/TB prevention, care and support programmes throughout the country;

e) Ensure that HIV/AIDS/STD education, care and support are incorporated in core functions of NGOs and other civil society stakeholders.

3.4. Advocacy and Social Mobilisation

In order to achieve the highest levels of social mobilisation and commitment in the fight against HIV/AIDS/STI/TB, Government shall;

a) Ensure that all national leaders are conversant with and understand the HIV/AIDS context and implications as well as their expected role in fighting the scourge;

b) Encourage and strengthen the role of the family and community as the basic structure of society and protection against HIV/AIDS.

3.5. Prevention and Control

In order to prevent and control the spread of HIV/AIDS/STI/TB, the following measures will be undertaken:

3.5.1. *Information, Education and Communication*

In order to achieve positive behavioural change through information, education and communication on HIV/AIDS/STI/TB Government shall:

a) Ensure that people throughout the country have access to clear and relevant HIV/AIDS/STI/TB information through appropriate channels;

b) Support and encourage the development of IEC material that is based on participatory methods involving the respective audience/population and using appropriate language;

c) Devise mechanisms for documenting innovations on responses to HIV/AIDS as they emerge and disseminate them to stakeholders in a timely manner;

d) Promote and undertake awareness campaigns on the need for male involvement in taking care of the chronically ill;

e) Introduce public education on the dangers of certain cultural and religious practices that perpetuate the spread of HIV/AIDS/STI/TB;

f) Mobilise and strengthen the mass media to promote HIV/AIDS/STI/TB prevention, control, care and impact mitigation policies and interventions.

3.5.2. *Life and HIV prevention Skills*

In order to impart appropriate HIV prevention skills to children and adolescents, Government shall:

a) Ensure that HIV/AIDS/STI/TB education which has been integrated in the school curricula are regularly reviewed and implemented;

b) Encourage parents' and guardians' ability to communicate with young people about sexuality, HIV/AIDS/STI/TB and develop their life skills;

c) Encourage and support integration of positive HIV/AIDS/STI/TB education in traditional sexual socialisation institutions and activities;

d) Support IEC interventions targeting out-of-school children and youths.

3.5.3. *Voluntary Counselling and Testing*

In order to make voluntary counselling and testing services available to all people in the country, Government shall:

a) Encourage the establishment of VCT centres which are accessible and affordable throughout the country;

b) Ensure that appropriate procedures, guidelines and standards for VCT services are developed and implemented;

c) Ensure that only HIV testing techniques and approaches that meet required national and international standards are utilised;

d) Strengthen and support counselling as an integral component of HIV/AIDS/STI/TB prevention, control and care;

e) Support appropriate training in HIV/AIDS/STI/TB and psychosocial counselling;

f) Establish and strengthen institutions offering counselling training.

3.5.4. *Barrier Methods and Condoms*

In order to make condoms available, accessible and affordable to all sexually active individuals throughout the country, Government shall:

a) Encourage the use of male and female condoms and other barrier methods in all sexual partnerships;

b) Ensure that condoms are easily accessible to sexually active people through various distribution channels;

c) Ensure the highest standards of condom quality through control measures and adherence to the current legal requirements under the Pharmacy and Poisons Act for registration for all products sold, offered and donated;

d) Ensure that proper instructions and information on the use and disposal of condoms and other barrier methods are provided using the relevant languages in the package and/or before issuing condoms.

3.5.5. *Provision of Safe Blood Transfusion Services*

In order to uphold highest standards of safety of all blood and blood products used for transfusion, Government shall:

a) Require the screening of all blood for HIV, syphilis, Hepatitis B and other infections before transfusion;

b) Ensure that effective blood donor recruitment and selection strategies are applied;

c) Ensure that appropriate procedures, guidelines and standards for blood bank services are implemented and reviewed;

d) Advocate for the availability of adequate and safe blood bank facilities in all districts;

e) Ensure that there is a mechanism of letting the beneficiaries know the safety of blood.

3.5.6. *Treatment of STIs*

In order to provide quality STI services at all levels of the health care delivery system, Government shall:

a) Ensure availability of appropriate infrastructure, equipment and drugs in all health facilities for all age groups and sexes;

b) Strengthen STI management skills of health workers and integration of this info-training curriculum.

3.5.7. *Prevention of Mother-to-Child Transmission (PMTCT)*

In order to minimise the vertical transmission of HIV from mother-to-child, Government shall:

a) Ensure that every pregnant woman has access to STI screening and treatment;

b) Provide specific information to the public on reduction of mother-to-child transmission of HIV and other STIs;

c) Encourage women and couples considering having a baby to seek VCT;

d) Facilitate and support the access to ARVs and treatment for STI for pregnant women;

e) Encourage infant feeding options in HIV positive mothers;

f) Support HIV positive women who choose not to breastfeed with information on appropriate alternatives and potential risks;

g) Endeavour to support the formulation of a package that supports an HIV positive mother and her baby in order to allow for survival of both mother and child.

3.6. Treatment, Care and Support

In order to provide effective and efficient treatment, care and support measures will be undertaken to address challenges under the following:

3.6.1. *Treatment of Opportunistic Infections and STIs*

In order to make comprehensive, cost-effective and affordable treatment of HIV/AIDS/STI/TB available throughout the country, Government shall:

a) Strengthen the capacity of the health care delivery system through provision of adequate resources;

b) Make the relevant essential drugs for treatment of opportunistic and STI infections available at all levels of the public health care system;

c) Support the development and use of standardised management protocols for HIV/AIDS/STI/TB in both public and private health institutions;

d) Provide health staff in public and private health facilities with appropriate training in HIV/AIDS/STI/TB education, counselling and management of opportunistic and STI infections;

e) Take a leading role in price negotiation efforts with manufacturers of opportunistic infection drugs and make them accessible and affordable.

3.6.2. *Antiretroviral (ARV) Drugs*

In order to increase the accessibility of ARV drugs and ensure their safe and equitable utilisation, Government shall:

a) Introduce and facilitate ARV drugs in the public health care system/sector;

b) Ensure the registration of ARVs brought into the country in accordance with the stipulations governing the procurement and use of drugs and medical supplies;

c) Take a leading role in price negotiation efforts with manufacturers of ARV drugs and make them accessible and affordable;

d) Strengthen efforts for enabling the procurement of ARV generics in the courts;

e) Create a revolving fund for procurement of ARV drugs;

f) Facilitate the establishment of facilities for manufacturing HIV/AIDS drugs in public and private sector;

g) Ensure that appropriate infrastructure and trained personnel are put in place throughout the country for utilization of ARVs.

3.6.3. *Traditional/Alternative Remedies*

In order to address the challenges of alternative remedies, Government shall:

a) Facilitate co-operation and collaboration between formal and traditional health practitioners in order to strengthen HIV/AIDS/STI/TB control and care;

b) Promote public awareness about the known benefits and limitations of the different sources of care to enable people to make informed choices;

c) Institute and apply measures to control claims of HIV/AIDS/STI/TB cures through one recognised body to be responsible for validation of the efficacy of the treatment regimen.

3.6.4. *Nutrition and HIV*

In order address the challenges associated with HIV and poor nutrition status, Government shall:

a) Ensure food security at household level;

b) Promote and strengthen nutrition interventions as an integral element of HIV/AIDS/STI/TB care and support at all levels;

c) Support access to micronutrient supplementation for PWA.

3.7. Support to Affected and Infected

In order to appropriately address the needs of individuals with HIV/AIDS/STI/TB, their families and communities that pose a serious challenge to the health care delivery and the social welfare systems, measures will be undertaken under the following:

3.7.1. *Continuum of care for PWA*

In order to provide a continuum of care for PWA throughout the country, Government shall:

a) Ensure that the referral system adequately caters for PWA;

b) Promote and strengthen hospice services and other forms of palliative care;

c) Promote quality-nursing care and strengthen basic nursing-skills by service providers, volunteers, family members and others as an essential component of PWA care;

d) Encourage the involvement of beneficiaries, households and support groups in formulating prevention, care and support plans.

3.7.2. *Home-Based Care*

In order to fully develop community- and home-based care (HBC) and support it as an essential component of the continuum of care for PWA and their families, Government shall:

a) Support the communities and families to engage in HBC;

b) Strengthen primary health care and social welfare system to support HBC.

3.7.3. *Orphans*

In order to address the challenges of orphans, Government shall:

a) Devise a mechanism for identification of orphans;

b) Create a data bank;

c) Provide guidelines on the orphanages and their operations;

d) Mobilise sufficient resources to support orphan care;

e) Promote orphan care mainly within and through the community;

f) Support training of health personnel and other youth practitioners in counselling young people on sexual and reproductive health.

3.7.4. *Caring for Care Providers*

In order to address problems experienced by care providers, Government shall:

a) Provide psychosocial support and appropriate skills for care givers;

b) Devise to address burnout syndrome among service providers.

3.8. High Risk and Vulnerable Groups

3.8.1. *Poverty Reduction*

In order to achieve the highest levels of social mobilisation and commitment in the fight against HIV/AIDS/STI/TB, Government shall re-orient resources to enhance rural development as a way of addressing poverty and food insecurity.

3.8.2. *Commercial Sex Work*

In order to address the challenges of HIV transmission in sex work and reduction of HIV transmission, Government shall:

a) Enforce the provision of the existing law and provide facilities for the rehabilitation of sex workers;

b) Target clients of sex workers with appropriate information and education and encourage them to take responsibility for their partners' sexual health.

3.8.3. *Prisoners, Refugees, Truckers, Fish Traders*

In order to ensure that all people mentioned are protected from HIV infections, Government shall:

a) Provide all the above mentioned groups with accurate, clear and relevant information throughout the period of detention to assist them avoid HIV/STD/TB;

b) Ensure that the groups have access to HIV voluntary counselling and testing on admission to custodial remand or imprisonment;

c) Initiate and promote detection and treatment programmes;

d) Strengthen measures to reduce chances and sexual abuse;

e) Encourage the use of and provide condoms.

3.9. Human Rights, Stigma, Discrimination and Ethical Issues

3.9.1. *HIV Testing in order to provide guidance on HIV testing.*

Government shall:

a) Encourage voluntary counselling and testing for all persons and maintain confidentiality by service providers;

b) Legalise mandatory testing in the case of persons charged with any sexual offence that could involve risk of HIV transmission;

c) Not encourage anonymous testing without consent except in research where it is anonymous.

3 9.2. *Partner Notification*

In order to bring about shared confidentiality that is desirable to promote prevention, better care and coping with HIV/AIDS, Government shall legislate against individuals who deliberately and knowingly withhold their HIV status from their partners/spouses.

3.9.3. *Stigma and Discrimination*

Government, in order to eliminate stigma and achieve human and constitutional rights for HIV infected people, shall:

a) Promote education and information to the public to eliminate discrimination against PWA;

b) Encourage the insurance industry to develop and apply policies, which take into account the insurance needs of persons with HIV/AIDS.

3.9.4. *Differently Abled Persons*

In order to resolve the challenges associated with people with different abilities, Government shall integrate the HIV/AIDS/STI/TB services required by people with different abilities in the existing health and social welfare delivery systems.

3.9.5. *Children and Young People*

In order to protect the rights of children and young people and avail them access to HIV/AIDS/STI/TB prevention and care services throughout the country, Government shall:

a) Ensure that parents and guardians of street kids are located, penalised and made to fulfil their child rearing obligations;

b) Ensure that children and young people, regardless of their HIV status, enjoy all their rights as enshrined in the African Charter, UN Convention on the Rights of the Child and the relevant Zambian laws;

c) Ensure that confidentiality of children's HIV status is strictly maintained and only communicated to the child or parents or guardians or prospective foster parents in the interest of the child;

d) Support training of health personnel and other youth practitioners in counselling young people on the dangers of early sex, unwanted pregnancies, and prevention of HIV/STDs.

3.9.6. *Wilful Transmission of HIV*

Government, in order to provide a framework for dealing with wilful transmission of HIV, shall:

a) Legislate against wilful transmission of HIV/AIDS;

b) Put in place support systems for victims and offenders in the form of counselling, education, information, rehabilitation and appropriate therapy.

3.10 Gender

In order to effectively mainstream, Government shall:

a) Adopt a gender-based approach to planning and implementation of programmes;

b) Strengthen the environment of existing legislation dealing with sexual harassment, abuse and violence.

3.11. Research and Development

3.11.1. *Research*

In order to promote HIV/AIDS/STI/TB research, Government shall:

a) Develop an agenda in HIV/AIDS/STI/TB research.

b) Encourage and strengthen research related to HIV/AIDS/STI/TB;

c) Encourage research and evaluation of traditional/alternative remedies in the prevention, management and care of HIV/AIDS/STI/TB and other related infectious diseases;

d) Facilitate infrastructure development, capacity building for HIV/AIDS/STI/TB research;

e) Mobilise resources to promote and support identified priority research and application of research findings.

3.11.2. *Vaccine Development*

In order to encourage vaccine research and development, Government shall:

a) Mobilise resources to support vaccine development;

b) Ensure Zambia's participation in vaccine development.

3.12. Monitoring and Evaluation

In order to strengthen monitoring and evaluation of various interventions, Government shall:

a) Support the establishment of an effective surveillance system;

b) Establish and strengthen the existing information systems;

c) Facilitate the development of a national databank and clearing house.

4.0. IMPLEMENTATION FRAMEWORK

4.1. Institutional Framework

4.1.1. The body to be charged with the responsibility of directing the national effort in the control and prevention of HIV/AIDS shall be the National HIV/AIDS/STD/TB Council.

4.1.2. The National HIV/AIDS/STD/TB Council shall be placed under the highest Government office in the land.

4.1.3. Establish and/or strengthen structures for effective co-ordination of the multi-sectoral response at national, provincial, district and community levels.

4.2. Legal Framework

4.2.1. To address the problems of HIV/AIDS/STI/TB, Government shall:

a) Enact a principal and comprehensive Act to:
   - i. Support the implementation of the National HIV/AIDS/STI/TB Policy;
   - ii. Provide the legal framework for the establishment of the Council.

b) Amend and harmonise all the relevant pieces of legislation. These will include the provisions in the National Health Service Act Cap 315, the Public Health Act Cap 295 and Employment Act Cap 268.

4.3. Resource Mobilisation

4.3.1. For the policy to be effectively implemented and on a sustainable basis, there will be need for adequate funding. In this regard, Government shall:

a) Establish a National HIV/AIDS Trust Fund;

b) Make annual allocations in the National Budget.

4.3.2. In addition, Government shall raise funds from other sources.

4.4. Policy Implementation Strategies

The Policy shall be translated into the National Strategic Framework addressing all the issues therein.

4.5. Policy Monitoring and Evaluation

Government shall support the co-ordinating body to develop monitoring tools for monitoring and evaluating implementation.

CASE STUDY:

The Combating of HIV/AIDS in Zimbabwe

INTRODUCTION

It is a fact that the AIDS pandemic is ravaging the world and that Sub-Saharan Africa is the worst affected region. Zimbabwe has not been spared as illustrated by the following statistics.

1. AIDS STATISTICS

The actual number of HIV/AIDS cases in Zimbabwe is not known due to lack of adequate data collection procedures, but according to projections based on available data, it is estimated that as at September 2000:

- More than 2 million people in Zimbabwe were HIV positive and more than 1.1 million had developed full-blown AIDS.
- There are 2000 new HIV infections each week.
- 2000 are dying from HIV/AIDS related illnesses each week.
- One in every four patients admitted to a hospital is HIV positive.
- Although 98% of Zimbabwe's population is aware of HIV/AIDS (how it is spread, methods of prevention), many do not perceive themselves as being in danger.
- The old cultural notion that a man shows his masculinity through being promiscuous still prevails.
- The largest number of reported AIDS cases is in the 20 to 49 year age group.
- The peak of HIV infection in men is around 25 to 39 years whilst for women it is in the 20 to 29 year age group.
- The chances of a partner being infected with HIV at marriage is 25% as the age of marriage coincides with the peak of the age of infection.
- 50% of HIV incidences occur under the age of 25 years, showing that youths practice high risk sexual behaviour.
- Tuberculosis is the biggest AIDS-related killer in Zimbabwe with 50,138 cases reported in 1999 and the figure is rising with each subsequent year.

- The high incidence of sexually transmitted infections, to an extent, shows the prevalence of unprotected sex amongst the population, with 696,172 cases treated in 1999 and 1,087,927 cases in 1998.
- The death rate amongst males due to HIV/AIDS is higher than amongst females.
- The mortality rate (per 100,000) has risen from 1.9 in 1987 to 43.1 in 1998.
- In Zimbabwe, HIV is mainly spread through heterosexual contact and from infected mother-to-child, before, during or after birth through breast milk.
- The age-gender prevalence curve for AIDS peaks in the 0 to 4 and the 30 to 39 age groups.
- Sub-Saharan Africa is the worst affected region in the world with about 28 million people infected.

2. IMPACT OF HIV/AIDS ON THE COUNTRY

AIDS threatens the social and economic well being of the country. Some of its effects are:

- Increase in the country risk profile leading to decreased foreign direct investment (FDI). This problem is exacerbated by reduced local savings.
- Decrease in labour quality and supply as the economically active age group dies. This will lead to less production for example in agriculture.
- Decrease in international competitiveness as wages increase as a result of the decrease in labour supply which may lead to forex shortages.
- Increased costs to society and employers through medical aid, absenteeism, funeral expenses, pensions and training or hiring, which consequently decreases company profits.
- Wasted investment in tertiary education as the beneficiaries die soon after qualifying.
- Straining of the national health budget and also that of medical aid institutions.
- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) leads to less investment and slower economic growth. This is worsened by the

diversion of resources from productive sectors to health services provision.

- Lost production time as people take sick leave and also attend funerals.
- Negative impact on staff morale as colleagues die, which can lead to greater labour-management tensions.
- HIV/AIDS places an enormous unpaid burden on women and girl children and threatens to undermine fragile advances in women's economic status.
- Decreased economic productivity of women as they spend more time caring for the sick.
- Research shows that the HIV infection risk is 2 to 4 times higher for women than men. Therefore the epidemic will undermine the fragile economic and social gains that have been made in the advancement of women.
- Impoverishment of families as they try to take care of the sick and meet funeral expenses and this is worsened by loss of income and remittances (if the family breadwinner is infected and dies).
- An increase in the number of orphans (a child under the age of 15 who has lost his or her mother to AIDS - showing the central role of a mother in child caring).The increase in the number of orphans puts a strain on Government's social welfare budget and the extended family. This will also result in grandparents becoming parents again, child-headed families and more street children.
- This sometimes leads to withdrawal of children from school and severe loss of future earning potential.

3. LEGISLATIVE INTERVENTIONS

There are a number of Acts passed by Parliament that are in place to try and control the spread of HIV/AIDS as well as mitigate its effects on the populace. Examples of these are:

- **The National AIDS Council Act [Chapter 15:14].** This Act established the National AIDS Council of Zimbabwe (NAC) and also gave authority to the government to introduce the AIDS Levy in January 2000 at 3% of all taxable individuals income and companies tax.The money is held in the National AIDS Trust Fund.

- **Public Health Act [Chapter 15:09]**. This Act makes it the duty of government to provide health services to all those who need them. However, budgetary constrains are negatively impacting on government's ability to provide this necessary service.
- **Child Protection and Adoption Act [Chapter 5:06]**. The Act established the Child Welfare Council, which deals with issues concerning the welfare and upbringing of children. The Act also gives permission for adoption of such children as normal orphans and AIDS orphans. Therefore it protects orphans and other disadvantaged children like street children from abuse. However, there is still a culturally linked reluctance to adopt, especially a child one is not related to at all.
- **Sexual Offences Act [Chapter 9:21]**. This Act tries to prevent sexual exploitation of both the young and mentally handicapped both inside and outside Zimbabwe. In addition it empowers the police to arrest prostitutes thereby reducing the spread of HIV/AIDS. Under the Act, mandatory testing for HIV/AIDS becomes possible for those found guilty of sexual abuse.
- **Education Act [Chapter 25:04]**. The Act compels the Minister of Education to provide funding to disadvantaged students at primary, secondary and tertiary levels. This helps in preventing the spread of HIV/AIDS because girls at colleges and universities are usually abused by sugar daddies (older men) as they try to earn fees and a living through prostitution. The Act also works in conjunction with the Manpower Development Act.
- **Traditional Medical Practitioners Act [Chapter 27:14]**. The Act authorises traditional healers to identify, analyse and treat without the application of operative surgery any illness of the body and mind using traditional methods. Whilst they have come up with various medicines like the African Potato, which they believe will suppress or stop the HIV/AIDS symptoms, awareness campaigns need to be directed at this group as to the use of unsterilised instruments like razor blades which will exacerbate the spread of the pandemic.
- **Labour Relations Act [Chapter 28:01].** The main contribution of this Act is that it does not allow discrimination of anyone on the grounds of his/her HIV status.

- Other Acts which contribute to the prevention, control and mitigation of the HIV/AIDS pandemic are for example, Customary Marriages Act [Chapter 5:07], Guardianship of Minors Act [Chapter 5:08] and the Legal Age of Majority Act [Chapter 8:07].

4. INSTITUTIONAL ARRANGEMENTS

Zimbabwe has put in place a number of institutions to deal with the scourge. These are:

- **National AIDS Council (NAC)** that is under the Ministry of Health and Child Welfare and below it Provincial AIDS Councils and District AIDS Action Councils which are multi-sectoral committees. The NAC is mandated to stimulate, co-ordinate, facilitate and monitor the multi-sectoral national response to HIV/AIDS. It works closely with labour organisations, non-governmental organisations (NGOs) and churches to chart the way forward. It also administers the AIDS Levy.
- **Health and Child Welfare Parliamentary Committee**, which is a portfolio committee shadowing the activities of the Ministry including NAC.
- **Community Home-Based Care** which provide care and support for the affected community members.
- **New Start Centres** have been established that offer voluntary counselling and testing to the populace. There are 12 of these in the country, that is one in each of the 10 provinces, with the exception of Harare and Bulawayo, the major cities, which have two centres each.
  - Drawing up of the National AIDS Policy that came into effect in December 1999 and 5-year medium-term plans, which have been drawn since 1988.The current one runs from 2000 - 2004.
  - Establishment and training of HIV/AIDS focal persons in each government ministry who will promote, co-ordinate and monitor AIDS activities within their workplaces. Provincial/City AIDS co-ordinators were also established within the office of the Provincial/City Medical Director.
- The Zimbabwe National Network of People Living with HIV/AIDS (ZNNPLH) which plans and co-ordinates AIDS interventions targeted at people living with HIV/AIDS.

5. PROGRAMMES IN PLACE

- Free Tuberculosis treatment throughout the country, which has been in place for several years now. This is contributing a lot to the national effort as TB is the leading AIDS-related killer disease in the country.
- Voluntary testing and counselling services to the population at a minimal fee of $50 at the New Start Centres. On special occasions, like St. Valentine's Day, free testing and counselling is offered to encourage more people to visit them.
- National AIDS Council Programmes which are identified by the communities to benefit.These include:
    - Awareness programmes through posters, leaflets, and pamphlets. These include education material that deal with such issues as practical ideas about preparing nutritious meals for people with HIV/AIDS and how to deal with some common infections;
    - Orphanages;
    - Education provision;
    - AIDS-related medical institutions; and
    - Income generating projects for those still able to work.

Thus, between April 2000 and November 2001, NAC disbursed over $665.846 million to fund these projects. Of this, 24.3% went to 89 private organisations like NGOs, 21.1% to 9 sector ministries or departments, 0.51% to 4 local authorities and 54.13% to 71 District AIDS Action Committees.

- Distribution of condoms through Population Services International (P.S.I.) and to a lesser extent the National Family Planning Council (NFPC). In 2000 for example, 50 million condoms were distributed.
- Community Home-Based Care Scheme is a programme that encourages the community to look after the sick people in their communities. They are helped with essentials such as basic care training and gloves by the NACP.
- People living with HIV/AIDS Support Groups are mushrooming in the country with the continued spread of the disease. These actively involve people living with HIV/AIDS and provide psychosocial, spiritual and financial support, share experiences and participate in home visits. These community activities help change people's attitudes with respect to HIV/AIDS and reduce discrimination and stigmatisation.

- Training support group members in various HIV/AIDS-related areas, for example counselling and community education are undertaken by the government and NGOs.
- The National Monitoring and Evaluation Unit which monitors and evaluates HIV/AIDS and STD programmes in Zimbabwe.
- Orphan support projects and community food security projects, for example Zunde Ramambo which can supply food to orphans when the need arises.
- Traditional healers training programmes in infection control, counselling and challenging retrogressive cultural norms and practices are taking root in a number of districts.

6. RELATIONSHIP BETWEEN THE LEGISLATURE AND EXECUTIVE IN COMBATING AIDS

These two of the three pillars of state play a very important complementary role characterised by:

- Coming up with legislation that effectively deals with the pandemic and ensures that the affected are not discriminated against or stigmatised but cared for.
- There is need for commitment on the part of the Executive to implement the laws and policies that the Legislature enacts.
- Members of Parliament (MPs) must give political support to the plans and strategies of the executive in combating AIDS.
- MPs and the Executive must be exemplary and acknowledge it if close relatives/friends die of AIDS rather than deny it.This will send a strong message to the electorate about the prevalence of the epidemic.
- MPs should promote AIDS awareness, especially during their rallies/political campaigns.
- Debating and devising national policy(ies) on HIV/AIDS. Zimbabwe for example has a National HIV/AIDS Policy (which came into effect in 1999) that provides a multi-sectoral guidance and strategic direction to tackle the epidemic.

7. PROBLEMS THE COUNTRY IS FACING IN PREVENTING/ COMBATING HIV/AIDS

- Inadequate budgetary allocations, e.g. in 2002, the Ministry of Health and Child Welfare bid for $27 billion but received $22 billion.

- The prohibitive cost of AIDS drugs mainly because there is no local production, e.g.Fluconazole, a drug which reduces opportunist disease attacks on AIDS sufferers, costs $2 199 per capsule and one needs 2 capsules per day. Thus the drug costs $30 786 per week and $123 144 per month which is well beyond the average monthly income of most Zimbabweans.
- Zimbabwe's prisons, which are overpopulated, have become breeding grounds for HIV/AIDS.
- Social, cultural and gender barriers to prevention and control, e.g. the cultural practice of inheriting wives at the death of a brother or relative is still rampant and disregards the implications of HIV and AIDS.
- Brain drain of experienced medical personnel due to poor salaries and working conditions.
- Quality of care given to people living with HIV/AIDS was compromised due to inadequate training and support of the family care-givers and community volunteers.
- Unstable macro-economic environment, which is worsening poverty amongst the people. This is leading to risky sexual behaviour.
- Denial and stigmatisation that are obstacles to openness about HIV/AIDS and issues of sexuality.
- Need to build capacity at the distinct level for planning, co-ordination, monitoring and evaluation as well as management resources given.
- High reproductive rate of HIV infection.
- Bringing together stakeholders with different and sometimes opposing opinions and diverse interests to work against HIV/AIDS.
- Getting people to voluntarily go for testing and counselling.

CONCLUSION

It appears that neither drugs nor vaccines will contribute much to reduce the heterosexual spread of HIV, not only in Zimbabwe, but all our countries as well in the next several years. Therefore, behavioural change remains the cornerstone of the prevention of HIV. This remains the cheapest, surest and most sustainable solution to the problem of HIV/AIDS.

GENDER AND HIV/AIDS

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A. INTRODUCTION

HIV/AIDS is fast spreading in Africa making it a major developmental challenge as different African governments seek to combat poverty necessitating the development of strategic decisions aimed at meeting the challenge of the epidemic. The UNDP Administrator, Mark Malloch Brown, aptly summarises the extent of the challenge in a statement,

"AIDS is devastating in terms of creating and deepening poverty, reversing achievements in education and diverting meagre health budgets away from other priorities. And by cutting deep into all sectors of society, HIV/AIDS undermines vital economic growth perhaps reducing future GDP in Africa by a third over the next 20 years. Moreover, by putting huge additional demand on already weak, hard to access public services, it is setting up the terms of a desperate conflict over inadequate resources."[6]

The 2000 SADC Human Development Report has pointed out that "most recent information indicates that most of the countries in Sub-Saharan Africa hardest hit by the scourge are located in Southern Africa.... nine SADC countries have seen a reversal of their gains in life expectancy between 1990 and 1998"[7]. Statistics for 1999 further indicate that Botswana has the highest adult prevalence rate (36.1%) with Mauritius having the lowest adult prevalence rate (0.8%)[8]. The epidemic is however affecting the SADC countries in different degrees, though a common characteristic of the epidemic in this region is the link to cross-border movement necessitating strategies that go beyond national borders.

The strategies developed to tackle the epidemic have to adopt a multifaceted approach that deals with various issues ranging from mainstreaming HIV/AIDS priorities into mainstream development planning,

[6] Leadership for Results: UNDP's Role in the Fight Against HIV/AIDS, June 2001
[7] SADC Human Development Report 2000:Challenges and Opportunities for Regional Integration, pp 149 - 150
[8] Ibid, p. 147

policies and legislation, to dealing with issues of discrimination and human rights of persons living with HIV/AIDS and gender inequalities.

B. GENDER AND HIV/AIDS

Whereas concerted efforts have been made at information awareness that encourages safe sex, these have not taken into account the context within which people are continuing to take risks, even though well informed about the consequences of such actions. Moreover, such efforts have failed to take into consideration the increase in gender disparities in the infection rates despite statistics showing a higher prevalence rate amongst women than men. For example, recent statistics show that in South Africa, young women aged 20 to 30 years have the highest prevalence rates and those aged below 20 years have had the highest percentage increase as compared to any other age group in 1998[9]. Furthermore, the June 2000 UNAIDS report on Global HIV/AIDS indicates that in Sub-Saharan Africa, 55% of adult infections are among women (i.e. 8 million out of the 10 million infected women worldwide).

The Declaration of Commitment (DOC)[10] on HIV/AIDS recognises, amongst other things, the vulnerability of women and girls to HIV/AIDS, and in particular that in all social dimensions gender inequalities fuelled by unequal power relations between men and women have contributed to the perpetuation of the epidemic. Paradoxically, whereas women have been at the forefront of information campaigns, many are still not able to protect themselves from infection due to factors such as sexual abuse, domestic violence, cultural constraints, economic pressures to support their families, to name but a few. Article 62 of the DOC calls upon all countries to strategize on how to address issues of personal vulnerability, empowerment of women and reducing social exclusion.

Weak internal policies in Sub-Saharan Africa have greatly contributed to gender disparities, which have in turn contributed to the spread of the epidemic. As women in Africa continue to bear the negative consequences of gender inequalities, more women who are in one-partner relationships are becoming infected, raising questions as to why this is happening. A

[9] Unpublished Report of the Joint Monitoring Committe on the Improvement of the Quality of Life and Status of Women, South Africa: November 2001

[10] The Declaration of Commitment on HIV/AIDS adopted by the UNGASS on HIV/AIDS on 27th June 2001

number of factors have contributed to this scenario thus necessitating different interventions:

1. Biological Vulnerability of Women

Women are biologically more vulnerable than men are to infection because, being receptive partners, women have a larger mucosal surface exposed during sexual intercourse. Again, semen has a far higher concentration of HIV than vaginal fluid. The vulnerability of women is further increased by sexual practices that encourage dry sex as a means of increasing pleasure. Moreover, infected pregnant women may transmit the HIV to their unborn babies or through breast-feeding.Often this is referred to as mother-to-child transmission, which a number of rights activists have criticised as placing the blame of transmitting the virus on the mother and have therefore called for the change of this to parent-to-child transmission.This they argue will go a long way in removing any stigma placed on the mother as well as combating a belief held by some that women are to blame for the transmission of the virus.

2. Unequal Power Relations

Women are powerless in sexual relationships and therefore are not able to be assertive to their partners. Due to their position in their families, women are unable to make decisions about sexual relations or their sexuality, more due to the various repercussions that often result in different forms of violence. Moreover, expectations arising out of marriage, childbirth and economic dependence often expose women to the virus.

Cultural practices that promote machoism are primarily responsible for the belief amongst men and boys that having multiple sexual partners is okay. Likewise are those beliefs that encourage unmarried men and younger boys to experiment sexually before marrying, which greatly places them and their partners at risk. Of great concern is the increase in girl child defilement cases, especially in South Africa, where it is argued that most of the defilers are HIV positive and defile the children as a way of cleansing themselves of the disease. Evidence shows that this is a belief commonly held in different parts of Africa and is linked to traditional healers who advise that the only cure for any form of sexually transmitted disease is having sex with a virgin.

Studies carried out in South Africa amongst young women aged below 20 years have indicated that young girls are often forced into unprotected sexual intercourse thus increasing their vulnerability to infection. Rape and

defilement are reflective of the powerlessness of women and young girls, the latter becoming an easy target for infected men who seek to cleanse themselves of the virus. Again, women are most likely to be assaulted within the confines of their family homes and by persons known to them. The vulnerability of women is increased tenfold in situations of conflict where enemy soldiers violate many as a form of punishment.

3. Correlation between the Feminization of Poverty and Increase in HIV/AIDS

A number of characteristics of the feminization of poverty illustrate the social impact of HIV/AIDS:

- Economic desperation forces some women to commercial sex work as a form of survival.
- As women who are the major producers of household food are infected, this inadvertently affects household food security. In addition, household food insecurity increases vulnerability to infection as intake of necessary nutrients is reduced.
- The majority of home carers are women and girls who need to be protected. In most homes women and girls carry the burden of caring, which invariably affects household food production, especially if we consider that in Africa women are in charge of subsistence farming. Due to the additional caring role of women, girl children in the family are often withdrawn from schools to make up for the lost labour in the household. Moreover, most carers are not well equipped with information on how to care for their sick relatives. In order to reduce the load of caring on healthy establishments, home-based care has to be developed to such an extent that it does not over-burden the existing roles of women, but at the same time ensures that those being cared for at home are well taken care of.
- Studies have shown a link between female illiteracy and increase of HIV/AIDS. Many girls in the SADC region tend to have less education and are therefore unable to access information.Many are married at an early age to older men who have had multiple partners thus increasing their vulnerability.
- As parents become infected, many children are taken out of school to undertake household chores which often affects girl children more than boy children.

- Abandonment of families, especially women widowed as a result of HIV/AIDS.

4. Inadequate Protection Under the Law

In particular one should note the inferior legal status of women in the region where women continue to be regarded as minors under both statutory and customary laws. The minority status means that many women are not able to negotiate safe sex with their partners, nor are they regarded as co-decision makers in the family or community. Whereas some countries in the region do have positive legislation that recognises women's majority status, customary laws continue to operate outside this law thus denying women this right.One such practice is that of widow cleansing or widow inheritance where a widow has to have sexual relations with a male relative even in cases where the deceased died as a result of HIV/AIDS and the widow may be infected too.

C. POSSIBLE STRATEGIES

1. Refocusing Behavioural Change Messages

Rapid increase in infection amongst women can be slowed down if concrete changes are made in the sexual behaviour of men who, in many societies, continue to be the key decision makers in the family as well as having greater control over sexual relations than women. However, it should be noted that information awareness alone cannot bring about change in behaviour. The messages must give people realistic and sustainable choices. Again, when peers, rather than authorities carry messages, they have a greater impact.The messages must however be targeted to specific groups using a language that is understood rather than providing generalised messages. Thus, for example, issues of safe sex should be discussed within the context of people's lives and relationships, as well as existing positive social cultural norms.

It is important to note that both men and women have to be active agents of social changes if we are to achieve any meaningful behavioural change. Thus the potential agents of change in a community should command a high degree of respect in the community and be regarded as custodians of the community's norms and practices. For example, if traditional healers and religious leaders are the revered leaders in the community, then messages targeting them as agents of change should be developed. Amongst women, elderly women as well as peer groups may be targeted. Achieving positive

behaviour change amongst all will go a long way in achieving desired goals of policies and programmes aimed at reducing the epidemic.

2. Development of Enabling Legislative and Policy Frameworks

It should be noted from the outset that laws alone cannot bring about the desired change but they can be used to facilitate a process that will bring about change. Again, in most African countries one cannot ignore the operation of customary or traditional laws, which continue to govern day-to-day lives of many people. The recommended laws should ensure that women have equal rights to ownership of property as well as inheritance. Furthermore, they should be protected from discrimination and harassment in the event of a spouse dying from HIV/AIDS. Other protective mechanisms should ensure that all persons living with HIV/AIDS are protected from all forms of discrimination. As stated above, societal norms and values continue to govern the lives of many people and these are deeply embedded in society to such an extent that they constrain the effective implementation of state law and policy. Thus, if policy is to be effective it has to "work with the forces which are changing norms and behaviours"[11] more so since culture is dynamic.

In conclusion, it is important to note that there is no one strategy that can be said to effectively work to deal with the gender disparities that fuel the HIV/AIDS epidemic. However, a multi-pronged approach that looks at women's lived realities and in the context of their lives should be adopted. This would not only focus on women alone, but would also seek to address those they interact with on a daily basis and who continue to shape the quality of women's lives. These include their children, partners, nuclear and extended family members, community, employers, religious leaders etc.

[11] Cohen, D & Reid, E.1998.The Vulnerability of Women:Is this harmful construct for policy nad programming? UNDP Issues Paper #28

INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS - HIV/AIDS, LAW AND HUMAN RIGHTS

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Key human rights, with examples of their specific application in the HIV/AIDS context, are:

- *nondiscrimination and equality before the law* i.e. eliminating discrimination against people living with HIV/AIDS in the areas of health care, employment, education, immigration, international travel, housing and social security;
- *health* i.e. ensuring equal and adequate access to the means of prevention, treatment and care, such as for vulnerable populations with lower social and legal status e.g. women and children;
- *privacy, both informational and physical,* e.g. ensuring confidentiality of HIV test results, and prohibiting mandatory or compulsory testing;
- *education and information* i.e. ensuring equal and adequate access to prevention education and information, such as targeted material for ethnic minorities;
- *freedom from inhuman, degrading treatment or punishment* e.g. prohibiting automatic isolation of HIV-positive prisoners;
- *autonomy, liberty and security of the person* e.g.prohibiting HIV testing or research without informed consent and prohibiting detention or quarantine solely on the basis of HIV status;
- *sharing in scientific advancement and its benefits* e.g. ensuring equal and adequate access to a safe blood supply and universal infection control protocols or treatment drugs;
- *work* e.g. prohibiting dismissal of staff solely on the basis of their HIV status;
- *freedom of expression, assembly and association* e.g. ensuring availability of registration for groups of people living with HIV/AIDS, such as sex workers or men who have sex with men;

- *participation in political and cultural life* e.g.ensuring the participation of persons living with HIV/AIDS in the formulation, implementation and evaluation of policy;
- *marry and found a family* e.g. prohibiting mandatory premarital testing and coerced abortions or sterilizations.

A. INSTITUTIONAL RESPONSIBILITIES AND PROCESSES

Guideline 1: National framework

States should establish an effective national framework for their response to HIV/AIDS, which ensures a co-ordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government.

Guideline 2: Supporting community partnership

States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organisations are enabled to carry out their activities, including in the fields of ethics, law and human rights, effectively.

B. LAW REVIEW, REFORM AND SUPPORT SERVICES

Guideline 3: Public health legislation

States should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

CHECKLIST - PUBLIC HEALTH LAW

1. Does the legislation empower public health authorities to provide the following comprehensive prevention and treatment services:
   - information and education;
   - voluntary testing and counselling;
   - STD, sexual and reproductive health services;
   - means of prevention, i.e. condoms and clean injecting equipment;
   - medication including pain prophylaxis? ☐

2. Does the legislation require specific informed consent, with pre- and post-test counselling, to be obtained from individuals before they are tested for HIV in circumstances where they will be given the results of the test (i.e. not unlinked, sentinel surveillance)? Does the legislation provide for any exceptions to individual testing with informed consent only with judicial authorisation? ☐

3. Does the legislation only authorise the restriction of liberty/detention of persons living with HIV on grounds relating to their behaviour of exposing others to a real risk of transmission (i.e. not casual modes, such as using public transport), as opposed to their mere HIV status? Does the legislation in such cases provide the following due process protections:

   - reasonable notice of case to the individual;
   - rights of review/appeal against adverse decisions;
   - fixed periods of duration of restrictive orders (i.e. not indefinite);
   - right of legal representation? ☐

4. Does the legislation authorise health-care professionals to notify sexual partners of their patients HIV status in accordance with the following criteria:

   - counselling of the HIV-positive patient has failed to achieve appropriate behavioural change;
   - the HIV-positive patient has refused to notify or consent to notification of the partner;
   - a real risk of HIV transmission to the partner exists;
   - the identity of the HIV-positive patient is concealed from the partner where this is possible;
   - necessary follow-up support is provided to those involved? ☐

5. Does the legislation provide for protection of the blood, tissue, and organ supply against HIV contamination (i.e. requiring HIV testing of all components)? ☐

Guideline 4: Criminal laws and correctional systems

States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

CHECKLIST - CRIMINAL LAW

1.	Does the law provide for the legal operation of needle and syringe exchanges? Are intermediaries (i.e. clients who distribute to third parties) covered by such protection, and is the evidentiary use of needles and syringes with trace amounts of illegal drugs restricted (e.g. immunity for contents of approved disposal containers)?	☐
2.	Does the law allow the following sexual acts between consenting adults in private: • homosexual acts, e.g. sodomy; • fornication or adultery; • street sex work; and • brothel or escort sex work?	☐
3.	If sex work is prohibited, or there are prostitution-related offences, is there any exception for HIV prevention and care services (e.g. evidentiary immunity for carrying condoms)?	☐
4.	Does the legislation regulate occupational health and safety in the sex industry to require safer sex practices to be: • practiced by clients; • practiced by workers; and • promoted by owners/managers (including prohibiting the requirement of unsafe sex)?	☐
5.	Does the legislation protect sex workers, including children, from coercion and trafficking? Is the object of such protection the removal and support of such workers, rather than criminalizing their behaviour as opposed to those responsible (i.e. owners or intermediaries)?	☐
6.	Does the law provide for general, rather than specific, offences for the deliberate or intentional transmission of HIV?	☐

CHECKLIST - PRISONS/CORRECTIONAL LAWS

1.	Does the legislation provide for access equal to the outside community to the following HIV-related prevention and care services in prisons or correctional facilities: • information and education; • voluntary testing and counselling; • means of prevention, i.e. condoms, bleach and clean injecting equipment; • treatment, e.g. post-exposure prophylaxis; • participation in clinical trials (if available)?	☐
2.	Does the legislation provide for protection of prisoners from involuntary acts that may transmit the virus, i.e. rape, sexual violence or coercion?	☐
3.	Does the legislation provide for confidentiality of prisoners' medical and/or personal information, including HIV status?	☐
4.	Does the legislation not require segregation of prisoners, merely on the basis of their HIV status, as opposed to behaviour?	☐
5.	Does the legislation (e.g. sentencing) provide for medical conditions, such as AIDS, as grounds for compassionate early release or diversion to alternatives other than incarceration?	☐
6.	Does the legislation provide for non-discriminatory access to facilities and privileges for HIV-positive prisoners?	☐

Guideline 5: Antidiscrimination and protective laws

States should enact or strengthen antidiscrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

CHECKLIST - ANTIDISCRIMINATION LEGISLATION

1. Does the legislation provide for protection against discrimination on the grounds of disability, widely defined to include HIV/AIDS? ☐

2. Does the legislation provide for protection against discrimination on the grounds of membership to a group made more vulnerable to HIV/AIDS, e.g. gender, homosexuality? ☐

3. Does the legislation contain the following substantive features:
   - coverage of direct and indirect discrimination;
   - coverage of those presumed to be infected, as well as carers, partners, family or associates;
   - coverage of vilification;
   - the ground complained of only needs to be one of several reasons for the discriminatory act;
   - narrow exemptions and exceptions (e.g. superannuation and life insurance on the basis of reasonable actuarial data);
   - wide jurisdiction in the public and private sectors (e.g. health care, employment, education, accommodation)? ☐

4. Does the legislation provide for the following administrative features:
   - independence of a complaint body;
   - representative complaints (e.g. public interest organisations on behalf of individuals);
   - speedy redress, e.g. guaranteed processing of cases within a reasonable period, or fast-tracking of cases where the complainant is terminally ill;
   - access to free legal assistance;
   - investigatory powers to address systemic discrimination;
   - confidentiality protections, e.g. use of pseudonyms in reporting of cases? ☐

5. Does the legislation provide for the institution administering the legislation (e.g. human rights commission, or ombudsperson) to have the following functions:
   - education and promotion of human rights;
   - advising government on human rights issues;
   - monitoring compliance with domestic legislation and international treaties and norms;
   - investigating, conciliating, resolving or arbitrating individual complaints;
   - keeping data/statistics of cases and reporting on its activities?

☐

CHECKLIST - EQUALITY OF LEGAL STATUS VULNERABLE POPULATIONS

1. Does the law ensure the equal legal status of men and women in the following areas:
   - ownership of property and inheritance;
   - marital relations e.g. divorce and custody;
   - capacity to enter into contracts, mortgages, credit and finance;
   - access to reproductive and STD health information and services;
   - protection from sexual and other violence, including rape in marriage;
   - recognition of de facto relationships;
   - prohibition of harmful traditional practices, e.g. female genital mutilation?

☐

2. Does the legislation prohibit mandatory testing of targeted or vulnerable groups such as orphans, the poor, sex workers, minorities, indigenous populations, migrants, refugees, internally displaced persons, people with disabilities, men who have sex with men, and injecting drug users?

☐

3. Does the law require children to be provided with age-appropriate information, education and means of prevention?

☐

4. Does the law enable children and adolescents to be involved in decision-making in line with their evolving capacities with regard to:
   - consenting to voluntary testing with pre- and post-test counselling;
   - access to confidential sexual and reproductive health services?

5. Does the law provide protection for children against sexual abuse and exploitation? Is the object of such legislation the rehabilitation and support of survivors, rather than further victimisation by subjecting them to penalties?

6. Does the law provide an equal age of consent for heterosexual and homosexual acts? Does the law recognise same-sex marriages or domestic relationships?

CHECKLIST - PRIVACY/CONFIDENTIALITY LAWS

1. Does the legislation provide for general privacy or confidentiality protection for medical and/or personal information, widely defined to include HIV-related data?

2. Does the legislation prohibit unauthorised use and disclosure of such data?

3. Does the legislation provide for the subject of the information to have access to his or her own records and the right to require that the data are:
   - accurate;
   - relevant;
   - complete;
   - up-to-date?

4. Does the legislation provide for the independent agency administering the legislation (e.g. privacy or data protection commissioner) to have the following functions:
   - education and promotion of privacy;
   - advising government on privacy issues;

- monitoring compliance with domestic legislation and international treaties and norms;
- investigating, conciliating, resolving or arbitrating individual complaints;
- keeping data/statistics of cases and reporting on its activities? ☐

5. Does other general or public health legislation provide for the right of HIV-positive people to have their privacy and/or identity protected in legal proceedings (e.g.closed hearings and/or use of pseudonyms)? ☐

6. Does public health legislation provide for reporting of HIV/AIDS cases to public health authorities for epidemiological purposes with adequate privacy protections (e.g. use of coded rather than nominal data)? ☐

CHECKLIST - EMPLOYMENT LAW

1. Does the legislation prohibit HIV screening for general employment purposes, i.e. appointment, promotion, training, and benefits? ☐

2. Does the legislation prohibit mandatory testing of specific employment groups, e.g. military, transport workers, hospitality/tourist industry workers, and sex workers? ☐

3. Does the legislation require implementation of universal infection control measures, including training and provision of equipment in all settings involving exposure to blood/body fluids, e.g. first aid, and health care work? ☐

4. Does the legislation require provision of access to information and education about HIV/AIDS for occupational health and safety reasons, e.g. workers travelling to areas of high incidence? ☐

5. Does the law provide for:
   - employment security while HIV-positive workers are able to work (e.g. unfair dismissal rules); and

- social security and other benefits where workers are no longer able to work?

6. Does the law provide for confidentiality of employees' medical and personal information, including HIV status?

7. Does workers compensation legislation recognise occupational transmission of HIV?

Guideline 6: Regulation of goods, services and information

States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.

CHECKLIST - THERAPEUTIC GOODS, CONSUMER PROTECTION LAWS

1. Does the legislation regulate the quality, accuracy and availability of HIV tests (including rapid or home testing, if approved)?

2. Does the legislation provide for approval to only be given for sale, distribution and marketing of pharmaceuticals, vaccines and medical devices if they are:
   - safe; and
   - efficacious?

3. Does the legislation provide consumers with protection against fraudulent claims regarding the safety and efficacy of drugs, vaccines and medical devices?

4. Does the legislation regulate the quality of condoms? Does such regulation include monitoring compliance with the International Condom Standard?

5. Does the legislation ensure the accessibility and free availability of the following prevention measures:
   - condoms;
   - bleach;
   - needles and syringes?

6. Does legislation make HIV/AIDS-related medication affordable, i.e. inclusion in subsidisation schemes for certain pharmaceuticals, and lack of duties/customs or tax? ☐

CHECKLIST - ETHICAL HUMAN RESEARCH

1. Does the law provide for legal protection for human subjects in HIV/AIDS research? Does the legislation require the establishment of ethical review committees to ensure independent, ongoing evaluation of research?
   Do the criteria used in such evaluation include the scientific validity and ethical conduct of research? ☐

2. Does the legislation require subjects to be provided before, during and after participation with:
   - counselling;
   - protection from discrimination;
   - health and support services? ☐

3. Does the legislation provide for informed consent to be obtained from the subjects? ☐

4. Does the legislation provide for confidentiality of personal information obtained in the process of research? ☐

5. Does the legislation provide for subjects to be guaranteed equitable access to the information and benefits of research? ☐

6. Does the legislation provide for nondiscriminatory selection of subjects? ☐

CHECKLIST - ASSOCIATION, INFORMATION, CODES OF PRACTICE

1. Does the law enable the unrestricted movement of people because of their membership of vulnerable groups, e.g. sex workers? ☐

2. Does the legislation enable the unrestricted association of members of vulnerable groups, e.g. gay men? ☐

3.	Does censorship legislation contain exceptions for general and targeted HIV/AIDS education and information?	☐
4.	Do broadcasting standards contain exceptions for general and targeted HIV/AIDS education and information?	☐
5.	Does the law require the following professional groups to develop and enforce appropriate HIV/AIDS Codes of Practice: • health-care workers; • other industries where there may be a risk of transmission, e.g. sex or funeral workers; • media; • superannuation and insurance; and • employers (in a tripartite forum involving unions and government)?	☐
6.	Are such Codes of Practice required to contain the following elements: • confidentiality/privacy protections; • informed consent to HIV testing; • duty not to unfairly discriminate; and • duty to minimise risk of transmission e.g. occupational health and safety standards including universal infection control pre-cautions?	☐

Guideline 7: Legal support services

States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilise means of protection in addition to the courts, such as offices of Ministries of Justice, ombudspersons, health complaint units and human rights commissions.

C. PROMOTION OF A SUPPORTIVE AND ENABLING ENVIRONMENT

Guideline 8: Women, children and other vulnerable groups.

States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children and other

vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

Guideline 9: Changing discriminatory attitudes through education, training and the media.

States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV/AIDS to understanding and acceptance.

Guideline 10: Development of public and private sector standards and mechanisms for implementing these standards

States should ensure that Government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

Guideline 11: State monitoring and enforcement of human rights

States should ensure monitoring and enforcement mechanisms to guarantee HIV-related human rights, including those of people living with HIV/AIDS, their families and communities.

Guideline 12: International co-operation

States should co-operate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues, and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at the international level.

Issues for Parliamentarians

Legislators and government policy-makers, because of their ultimate responsibility for designing and implementing HIV/AIDS policies, are the principal audience for which the *International Guidelines on HIV/AIDS and Human Rights* were aimed. Parliamentarians can advance HIV/AIDS and human rights issues generally at local, national and regional levels in several of their roles:

- as political leaders they can influence public opinion, and can increase public knowledge of relevant issues;

- as legislators they vote on acts of parliament and can ensure that legislation protects human rights, and advances effective prevention and care programmes;
- as advocates they can mobilise the involvement of government, private sector and civil society to discharge their societal responsibilities in responding appropriately to the epidemic; and
- as resource mobilizers they can allocate financial resources to support and enhance effective HIV/AIDS programmes that are consistent with human rights principles.

MEDICAL ISSUES:

Mother-to-Child Transmission (MTCT), HIV/AIDS Prevention, Therapy and Antiretroviral Drugs:The Question of Effectiveness, Cost and Accessibility

Dr. Flavia Mugala
Medical Doctor, Katutura Hospital

Prevention

- Abstinence;
- Be faithful;
- Condom promotion;
- Voluntary counselling and testing;
- Reducing stigma;
- Prevention of MTCT;
- Blood transfusion safety.

Treatment of HIV/AIDS

- Access to safe water, balanced diet, prevention and treatment of infections;
- Treatment and prophylaxis of opportunistic infections;
- Comprehensive care;
- Continuum of care;
- Antiretroviral treatment.

Post Exposure Prophylaxis

- Treatment for one month;
- Usually double therapy;
- Good counselling and follow-up is essential.

MTCT (1)

- Prevention of infection in women;
- Prevention of pregnancy in HIV+ women;
- MTCT regimens;
- Child feeding options;
- Comprehensive antenatal, intrapartum and postnatal care.

MTCT (2)

- Voluntary counselling and testing;
- Various MTCT regimens (Nevirapine at single dose most feasible);

- Child feeding options (exclusive breast feeding and early weaning, artificial feeding);
- Community involvement;
- Involvement of men.

ANTIRETROVIRAL TREATMENT (using 3 different drugs)

Advantages:

- Morbidity and mortality declines;
- Patients receiving treatment;
- Immune system recovers;
- Reduced cost of hospitalization and orphan maintenance;
- Reduced HIV MTCT.

Limitations:

- No cure, treatment should be taken life-long;
- Strict compliance of treatment required;
- Close monitoring to adapt treatment;
- Resistant strains can be transmitted by unprotected sex;
- Costs of monitoring.

Conditions for starting treatment

- Access to voluntary counselling and testing;
- Access to diagnostic and therapeutic services;
- Counselling of patient and his/her environment to ensure full understanding of treatment;
- Commitment to pay for life-long treatment, to comply with treatment, to practice safe sex.

THE SOCIAL, ECONOMIC AND POLITICAL IMPACT OF HIV/AIDS IN THE SADC REGION

Dr. Kalumbi Shangula
Permanent Secretary Ministry of Health and Social Services, Republic of Namibia

1. Introduction

There is no country on earth that can claim to be free of HIV and AIDS. However it is estimated that 70% of HIV/AIDS cases are found in Africa. It is estimated that 22 million people have died of AIDS since the beginning of the epidemic. Southern Africa has more people living with HIV/AIDS than any other region. It is estimated that 3.8 million people were infected with HIV in 2000 alone in Sub-Saharan Africa and 2.4 million people died of AIDS. It is also estimated that 25% of women between 20 and 29 years are infected with HIV.

2. The Socio-Economic and Political Impact of HIV/AIDS

The HIV/AIDS epidemic is not just a health issue, but a major development and security issue. It has major impact on all spheres of human endeavour. Its major determinants lie outside the health sector and therefore the disease requires an inter-sectoral approach to its resolution.

2.1. *Effect on the total population*

AIDS does not have a negative effect on the size of the population per se, in the sense that the size of the population will never become less. Whereas the size of the population will continue to increase over time, the rate at which this increase takes place is slower than what could have been the case in the absence of AIDS. AIDS has a significant effect on the demographic structure of the population.

2.2 *Effect on crude death rates*

The crude death rate represents the number of deaths per thousand people per year. AIDS leads to an increase in this rate. The occurrence of these deaths has a strong impact on both adult and child mortality rates. Life expectancy (number of years which a person is expect to live given the prevailing health situation) will initially decrease significantly, but later will gradually increase, although it will not reach the initial level.

2.3. *Effect on children*

Children are affected in two ways:

i. Children may be infected through their infected mother. The majority of them will die before the age of five years, thus increasing the child mortality rate.

ii. Those children, who escape infection from their infected mothers, will be orphaned, thus creating another social liability on the state.

2.4. *Impact at household level*

The disposition and death of a family member who is the money earner will impact negatively on household income. The household financial resources will be depleted by meeting medical costs, thus reducing household savings and exacerbating poverty. At one time or another, the affected members of the household will have to care for the infected member at home.

2.5. *Impact on women members of the household*

More women are infected with AIDS due to higher physiological susceptibility and less access to preventive measures. The burden of taking care of the sick will fall on the women and the burden of taking care of orphans falls on the grandmothers.

“When a husband becomes ill, it is the woman who nurse him.When a child is ill, it is the woman who nurse it. But when the woman becomes ill, she nurses herself”. Mugemana.

2.6. *Impact on education*

The learning process is affected in many ways:

i. Orphaned children are plugged in an environment which is not conducive to learning.

ii. The loss of parents leaves a vacuum for learning support outside the classroom.

iii. The demise of qualified teachers compromises the quality of education.

iv. The psychological trauma induced by loss of parents negatively affects the learning process.

2.7 *Impact on selected sectors of the economy*

Provision of services by government will be negatively affected as more than 80% of public servants are in the high-risk age group. The demand for services in health, education and social services will increase thus subjecting these sectors to a double burden. In the private sector, large proportions of employees fall within the vulnerable age group. In addition, the private sector employs a large proportion of unskilled and semi-skilled workers among whom the risks of contracting the disease are greater in view of their limited education. Agriculture, fisheries, tourism, mining and manufacturing are particularly vulnerable.

2.8. *Impact on the macro-economy*

It will be hard for country to attract investment since it is expected that productivity will be compromised by AIDS and economic growth will be stagnated. The annual growth rate will be greatly reduced in the AIDS environment.

3. SADC Response to the HIV/AIDS Epidemic

i. SADC Strategic 1 Framework and Programme of Action (2000-2004) calls for review, development and harmonisation of policies and legislation aimed at prevention and control of HIV/AIDS transmission.

ii. SADC Multi-sectoral Task Force on HIV/AIDS includes health, employment and labour, human resource development, culture, information and sports, mining, tourism, transport and communication sectors.

4. Guiding Principles for a Balanced Regional Response

i. Address gender inequalities that fuel the epidemic.

ii. Prevention methods and life-saving treatments must be made broadly available to all.

iii. People living with HIV/AIDS must be actively engaged and supported in combating the epidemic.

iv. National governments working in partnership with civil society must provide leadership and resources to fight the epidemic.

5. Challenges to Legislators

i. Enact laws that prevent all forms of discrimination in all spheres of life against those citizens who are infected and affected.

ii. Amend or repeal all those laws that permit discrimination on the basis of HIV status.

iii. Keep the HIV/AIDS agenda high on the list of priorities and ensure adequate allocation of funds in national budgets.

HIV/AIDS IN CORRECTIONAL SERVICES

Mrs. Michaela Hübschle
Facilitator of Criminals Return into Society (CRIS)

Introduction

The prevalence of HIV and its rate of transmission are extremely high and increasing at an alarming rate. With the release of the latest worldwide HIV/AIDS statistics by the United Nations and the World Health Organisation, there can be little doubt that HIV/AIDS will soon be known as the most deadly disease in human history. Nevertheless HIV/AIDS in prisons remains a matter of controversy.

In the broad community of every country, there is a small population that I believe receives very little attention. This population is the inmates in our prisons. I am representing an after-care organization called Criminals Return into Society (CRIS). Our motto is "nurturing a culture of care". With the above mentioned as our motto, we take care of inmates during and after their prison terms.

The situation in prison

The over-crowding in prisons, common to many parts of the world, and the difficulties in maintaining an acceptable hygiene standard under those circumstances, contributes to the spread of HIV/AIDS. We should not be ignorant about the existence of a subculture in prison and, whether we like it or not, we need to face reality. There is an increasingly desperate situation at hand.

Although many prisoners came into custody already infected with HIV, there are also those who are infected with the virus during their term of imprisonment.The common and the main method of transmitting HIV within prison is through homosexual activities.

HIV and homosexual activities in prison are a very sensitive issue. Some of the prisoners, and the Ministry itself, are not open enough about these issues. Homosexual activity is a reality in prisons and it is practised on a daily basis.

Homosexual activities may lead to sodomy, which is illegal and punishable according to the law. These activities are aided and made worse by the overcrowding of inmates in cells. In other circumstances, juveniles who do

not have outside supplies, are forced by their physical needs such as toiletries, cigarettes, food etc. and turning to those who have outside supplies to “take care” of them. As a result they make themselves available as “wives” to the other inmates who have outside supplies.

It is worthwhile mentioning that HIV positive prisoners will only be separated from other inmates in the terminal stage of their illness and may even be considered for release to die peacefully in their family-set-up.

Therefore we cannot justify the call for total separation or isolation of those HIV-positive inmates. Furthermore violence of any nature in our prison environment cannot be tolerated. CRIS wants to see more programmes being introduced dealing with anger treatment and anti-aggression training with clear conflict resolution options for inmates and personnel respectively.

The above-mentioned are the realities in our prisons. It is true that:

- unprotected sex is taking place in our prisons;
- this unprotected sex will lead to STDs;
- HIV/AIDS is a STD;
- the spread of this virus is quicker in prisons because it is a closed community.

Our organisation, CRIS, has a policy of distributing condoms in prisons. The intention is not to encourage sodomy or homosexual activities, which are a reality in prisons and do not need encouragement, but to prevent the spread of HIV.

It is my firm belief that harm reduction is the only way to find a path between competing and conflicting moral and legal imperatives. More effective HIV prevention and AIDS awareness programmes should be implemented but, without the necessary funds available, it remains a futile exercise.

We should address the needs of prisoners in a non-discriminatory and comprehensive manner. By entering our penal facilities, prisoners are serving their sentence and should not condemned to HIV/AIDS and STD infections as well. It is our true conviction that the policy employed by the Ministry of Prisons should conform with the general principles adopted by National AIDS Programmes as they apply to the general public. These policies should be developed in close co-operation with health authorities in the SADC region. We need to strengthen the spirit of solidarity, tolerance, compassion and understanding for people infected with HIV/AIDS, through knowledge and action.

The AIDS pandemic will be a challenge for years to come and we must definitely intensify our efforts to disseminate information, promote safe sex and take care of the infected and affected.

While it is true that HIV/AIDS is a health problem it is also a moral problem. We humbly submit that unless the moral problem is addressed, Namibia may not be able to see the rate of transmission drop, except if we take a collective stand on drastically changing our sexual behaviour. If not the consequence will be: "Welcome AIDS - goodbye life!"

We need to address how to change the views and attitudes that are contributing to a 'no-care' life-style. Sex education must be compulsory not only at schools but also prisons countrywide. Health promoters from the public and private sectors should act as volunteers working together with social workers in prisons to ensure that inmates find access to all the information they need, enabling them to make informed decisions and choices about their lives and their futures respectively.

Sexual behaviour will not change until beliefs about sexuality change. And if these do not change drastically, the end result for Namibia and the SADC region will be even more devastating. HIV/AIDS is a regional crisis, responsibility lies with our legislators and all of us to face this war and fight this epidemic in a more effective way.

In conclusion, we would ask the advice of this august conference on how to deal with this delicate and fragile situation, where according to me, very little is done to remedy the situation.

PARLIAMENTARY ACTION ON HIV/AIDS

Mr. Simon Wright
Policy Advisor UK All-Party Parliamentary Group on HIV/AIDS

History of All-Party Parliamentary Group on HIV/AIDS (APPG AIDS)

- Founded in 1986
- Context of high-level political response
- Context of All-Parliamentary Groups
- 160 members
- Focus on national and international

Activities of APPG AIDS

- Regular meetings with guest speakers
- Co-ordinated written/oral questions and debates
- Public and private meetings with ministers
- Briefings on implication of legislation
- Information for HIV/AIDS organisations
- Joint meetings with other All-Party Groups

Policy involvement in:

- The “liberal consensus”
- AIDS (Control) Act 1987
- Disability Discrimination Act
- National HIV/AIDS Strategy
- Immigration and asylum politics
- Sexual legislation
- International development responsibility
- Global Fund and UNGASS
- Human rights focus

Benefits of the group

- Well-informed advocates
- Cross-party consensus
- Links between community and government
- Greater influence with ministers
- Help set the political agenda
- Parliamentarians become ministers
- International links

Limitations

- HIV/AIDS loss of a political priority in UK
- Other parliamentary duties (voluntarily)
- Consensus building
- Political parties
- Medical model
- International perspectives

North and South?

- Concentrated or generalized epidemic
- Different systems of democracy
- Priority of HIV/AIDS
- Formal Committees (volunteers)

Human rights inquiry 2001

- International Guidelines HIV and Human Rights
- 1999 UNAIDS/IPU Handbook for Legislators
- Calls for written evidence
- Oral sessions
- Publications of report
- Pursuing policy recommendations
- www. appg-AIDS.org.uk (report)

LEGISLATIVE AND INSTITUTIONAL INTERVENTION STRATEGIES AND THE RELATIONSHIP BETWEEN THE LEGISLATURE AND THE EXECUTIVE IN COMBATING HIV /AIDS IN BOTSWANA

Hon. Robert Molefhabangwe
Chairperson SADC PF Standing Committee on HIV/AIDS,
Member of Botswana Parliament's HIV/AIDS Committee

In Botswana, the HIV/AIDS epidemic has been declared a national crisis as the country is considered to have the highest percentage of people living with HIV/AIDS. This has prompted an approach of a multi-sectoral national response, which encourages networking among stakeholders. In this regard Parliament and the Executive are a united front and constantly exhibit a positive and healthy relationship.

The national response is guided by strong government leadership involving the State President as the Chairman of the National AIDS Council (NAC), with the Parliament Special Select Committee Chairman as a member thereof. This is in line with the provision of the Terms of Reference of this Parliament AIDS Committee, which supports a partnership between NAC and the committee.

Furthermore, the Parliament Special Select Committee on HIV/AIDS is represented in the National Men Sector of NACA, which deals specifically with HIV/AIDS issues affecting men.This men's sector committee has been delegated by the State President with the responsibility to host and spearhead the world AIDS day commemorations in the last two consecutive years. It is imperative to note that the Parliament Special Select Committee on HIV/AIDS was instituted in 1998 to deal specifically with the HIV/AIDS pandemic in spite of the existence of the Parliament Health Committee because of it's significance. The vision of the committee is that *"the Parliament Special Select Committee on HIV/AIDS will be a catalyst in the effective control and management of HIV/AIDS."*

The mission is as follows:"We aim to sensitise the public, to promote and lead the campaign against the spread of HIV/AIDS in partnership with NAC."

Its Terms of Reference include inter-alia:

- To ensure and foster continued highest political engagement and leadership in the multi-sectoral fight against HIV/AIDS across the political spectrum;
- To promote and lead prevention and mitigation efforts of HIV/AIDS by political leadership at both national and local level;
- To guide and closely monitor the implementation of the national expanded response to HIV/AIDS as outlined in the Botswana Second Medium Term Plan II (MTP-II) for HIV/AIDS;
- To mobilise extra budgetary resources, if need be, to facilitate effective management of the HIV/AIDS epidemic. To this end, in 2000 the committee embarked on a 137 kilometre sponsored walk entitled "A Walk for Hope" as well as a dinner dance with its proceeds to the amount of P50 000 being donated two NGOs, namely the Coping Center for People Living with HIV/AIDS (COCEPWA) and Botswana Network of People Living with HIV/AIDS (BONEPWA);
- To liaise with the National AIDS Council in the development, review and adoption of necessary and critical national policies and laws as and when necessary to ensure effective control and management of the HIV/AIDS.

Moreover, the Committee has established a fund with First National Bank (account No. 62016247737) mainly to finance HIV/AIDS activities.

In further reference to the same Handbook on the provision of resource mobilisation, the Botswana Parliament has, in the current budget proposal, allocated P200 million for HIV/AIDS related activities including the introduction of antiretroviral drugs.

The Handbook for legislators on HIV/AIDS, Law and Human Rights provides for "political leaders to influence public opinion and to increase public knowledge of relevant issues." To this end, the committee prides itself in holding kgotla meetings (country wide tours) to sensitise the people about the dangers of the epidemic and to mutually reinforce HIV/AIDS prevention messages as well as influence the nation to shift their attitudes in favour of the struggle against the pandemic.

Moreover, the Committee holds radio talk shows on the pandemic. Dintlha ka bolwetsi ja AIDS is a five minute slot on Radio Botswana, aired every

week day at 06h55 and at 12h55, intended to further conscientise the nation on the dangers and effects of HIV/AIDS. The topics already covered include:

- Drug and alcohol abuse in relation to HIV/AIDS;
- Peer pressure;
- Sugar daddies/mummies;
- Commercial sex;
- Traditional culture practices;
- Women, sex and AIDS;
- Lesbianism;
- Prevention strategies to be undertaken by the youth among other topics.

In a nutshell, there is a good working relationship between the government and the legislature with Parliament evidently exhibiting an active role in combating HIV/AIDS pandemic.

PROGRAMME

Regional Workshop on the Role of Parliamentarians in Combating HIV/AIDS

21 - 23 FEBRUARY 2002

NAMIB ROOM 2, SAFARI COURT HOTEL WINDHOEK, NAMIBIA

DAY ONE:THURSDAY 21 FEBRUARY 2002

OFFICIAL OPENING

08h15 Delegates and Invited Guests to be seated

08h20 Arrival of the Guest of Honour, Hon. Dr. Libertine Amathila MP, Minister of Health and Social Services, Republic of Namibia

OAU and Namibia National Anthem

08h30 Remarks by Dr. Wolfgang Maier
Resident Representative, Konrad Adenauer Stiftung, Namibia

08h40 Keynote Address
Dr. Khin-Sandi Lwin, Chairperson of the UN Theme Group on HIV/AIDS, Namibia

09h10 Remarks by Hon Robert K. Molefhabangwe, MP
Chairperson of the SADC Parliamentary Forum Standing Committee on HIV/AIDS

09h30 Official Opening Address
Hon. Dr. Libertine Amathila, Minister of Health and Social Services, Republic of Namibia

10h30 Tea break and group photograph

Workshop programme

11h00 Programme explanation and workshop objectives

11h10 Members' expectations from the workshop

11h30 Case studies: Country reports on the impact of HIV/AIDS and the status of programmes, legislative and other intervention strategies.

13h00 Lunch

14h00 The Gender dimensions/implications of HIV/AIDS

	Presenter:	*Dr. Janet Kabeberi-Macharia, Gender and Development Specialist UNDP (SURF Southern Africa/Bureau for Development Policy)*
	Moderator:	*Hon. S Ntlabati, MP*
15h30	Tea Break	
15h45	International guidelines on HIV/AIDS and Human Rights - HIV/AIDS, Law and Human Rights	
	Presenter:	*Ms. Michaela Figueira, Project Coordinator AIDS Law Unit - Legal Assistance Centre Namibia*
	Medical Issues:	*HIV/AIDS prevention, therapy and antiretroviral drugs - the question of effectiveness, cost and accessibility, Mother-to-child transmission*
	Presenter:	*Dr. Mugala, Medical Doctor, Katutura Hospital*
	Moderator:	*Hon. L J Chimango, MP - Chairperson Standing Committee on Regional Integration*
19h00	Reception	

DAY TWO : FRIDAY 22 FEBRUARY 2002

08h30	The socio-economic and political impact of HIV/AIDS in the SADC Region	
	Presenters:	*Dr. Dirk Hansohm, Director Namibia Economic Policy Research Unit (NEPRU)* *Dr. Shangala, Permanent Secretary Ministry of Health, Namibia*
	Moderator:	*Hon. Dr. Willibrod Slaa, MP - Chairperson Standing Committee on Inter-parliamentary Co-operation*
10h30	Tea	
11h00	HIV/AIDS in Correctional Institutions	
	Presenter:	*Mrs. Michaela Hübschle, former MP Namibia*
12h00	HIV/AIDS Questions and answers	
	Presenter:	*Dr. Frisch, GTZ*
	Moderator:	*Hon. Teopolina N Mushelenga MP - Vice Chairperson Standing Committee on Gender, Democracy and Conflict Resolution/Peace Building*

13h00	Lunch	
14h00	Parliamentary action on HIV/AIDS	
	Presenters:	*Mr. Simon Wright, Policy Advisor, UK All-Party Parliamentary Group on HIV/AIDS* *Hon. Robert Molefhabangwe MP, Chairperson, SADC Parliamentary Forum Standing Committee on HIV/AIDS and member of Botswana Parliament's HIV/AIDS Committee*
	Moderator:	*Hon. V Baloomoody MP*
15h30	Tea break	
15h45	Plan of Action: Group sessions	

What can Parliaments and parliamentarians do to combat HIV/AIDS:

(i) At regional level;
(ii) At national level; and
(iii) At community level

Facilitators: *Dr. Frisch, Ms. Jessica Longwe*

DAY THREE: SATURDAY 23 FEBRUARY 2002

08h30 Plan of Action: Plenary session

What can Parliaments and parliamentarians do to combat HIV/AIDS;

(i) At regional level;
(ii) At national level; and
(iii) At community level

Facilitators: *Dr. Frisch, Ms. Jessica Longwe*

10h30 Communique and Closing remarks

15h00 Tour of the City of Windhoek

PARTICIPANTS IN THE REGIONAL WORKSHOP ON THE ROLE OF PARLIAMENTS IN COMBATING HIV/AIDS

Hon. A.F. Junior (Angola)
Hon. E. Gourgel (Angola)
Hon. R.K. Molefhabangwe (Botswana)
Hon. I. Davids (Botswana)
Hon. N. Motsamai (Lesotho)
Hon. L.J. Chimango (Malawi)
Hon. H.L. Zembere (Malawi)
Hon. V. Baloomoody (Mauritius)
Hon. Dr. R. Ng Man Sun (Mauritius)
Hon. M. Lampiao (Mozambique)
Hon. R. Namises (Namibia)
Hon. T. Mushelenga (Namibia)
Hon. K.A. Muharukua (Namibia)
Hon. E.G. Kaiyamo (Namibia)
Hon. S. Ntlabati (South Africa)
Hon. Dr. S. Cwele (South Africa)
Hon. Dr. W.P. Slaa (Tanzania)
Hon. 0. Kwaangw (Tanzania)
Hon. P.C. Katema (Zambia)
Hon. G.Z. Nyirongo (Zambia)
Hon. B. Chebubdo (Zimbabwe)
Hon. C.K. Majange (Zimbabwe)
Hon. Dr. Libertine Amathila M.P.
Dr. Wolfgang Maier
Dr. Khin-Sandi Lwin
Ms. Nicole Höpker, Student, St Pauls Secondary School
Dr. Janet Kabeberi - Macharia
Ms. Michaela Figueira
Dr. Flavia Mugala
Dr. Kalumbi Shangula
Mrs. Michaela Hübschle
Dr. Anne Frisch
Mr. Simon Wright
Ms. Jessica Longwe
Mr. Takawira Musavengana
Ms. Samuchine Kauvee

Information material

1. Advocacy for Action on Stigma and HIV/AIDS in Africa, 2001.
2. AIDS Toolkits.
3. All-Party Parliamentary Group on AIDS, The UK, HIV and Human Rights: recommendations for the next five years, 2001.
4. Excerpts from the speech that the President of the World Bank Mr James D. Wolfensohn held on January 10, 2000 at the UN Security Council. It reasons that - especially in Africa — AIDS has become a security issue.
5. HIV and AIDS Best Practices, The experiences from Botswana, 2000.
6. Human Science Research Council, Poverty Policy in the SADC Region: An Overview of Trends, Johannesburg, 2001.
7. Monitoring Regional Integration in Southern Africa Yearbook, Volume 1, Windhoek, 2001.
8. Nzima, Masauso, The Socio-Economic impact of HIV/AIDS: A Paper presented at the Regional Workshop on the role of Parliaments in combating HIV/AIDS, Windhoek, 2002.
9. SADC HIV/AIDS Strategic Framework and Programme of Action 2000 -2004, Managing the HIV/AIDS Pandemic in the Southern African Development Community, Windhoek, 2000.
10. SADC Parliamentary Forum. Towards a Regional Parliament
11. Sexual Health Exchange. SAfAIDS and KIT.
12. Take Control! Namibian HIV/AIDS Media Campaign.
13. The National AIDS Coordinating Agency (NACA), Botswana 2000 HIV Sero - prevalence and STD syndrome Sentinel Survey, A Technical Report, 2000.
14. UNAIDS. A human rights approach to AIDS prevention at work: The Southern African Development Community’s Code on HIV/AIDS and Employment, Geneva, 2000.
15. UNAIDS. Handbook for Legislators on HIV/AIDS, Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social impact, Geneva, 1999.

16. UNAIDS. HIV/AIDS and Human Rights, International Guidelines, New York and Geneva, 1998.
17. UNAIDS. The UNAIDS Guide to the United Nations Human Rights Machinery. For AIDS service organizations, people living with HIV/AIDS, and others working in the area of HIV/AIDS and human rights, 1997.
18. UNAIDS. UNAIDS Compendium on Discrimination, Stigmatisation and Denial: Research studies from India and Uganda.Comparative analysis of the two studies, Geneva, 2000, 2001.